

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19844

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilma D. ANKENEY			2a. DATE OF DEATH MONTH DAY YEAR July 12, 1983		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1020 Pope Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS 1020 Pope Avenue			21740		

14. FATHER'S NAME FIRST MIDDLE LAST Homer L. Philps			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Monroe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 717-07-9407A		17. INFORMANT ADDRESS William Ankeney, Hagerstown, Md.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>4149</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u> <u>year</u>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <u>Brone hial 9st Arterio</u>			
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

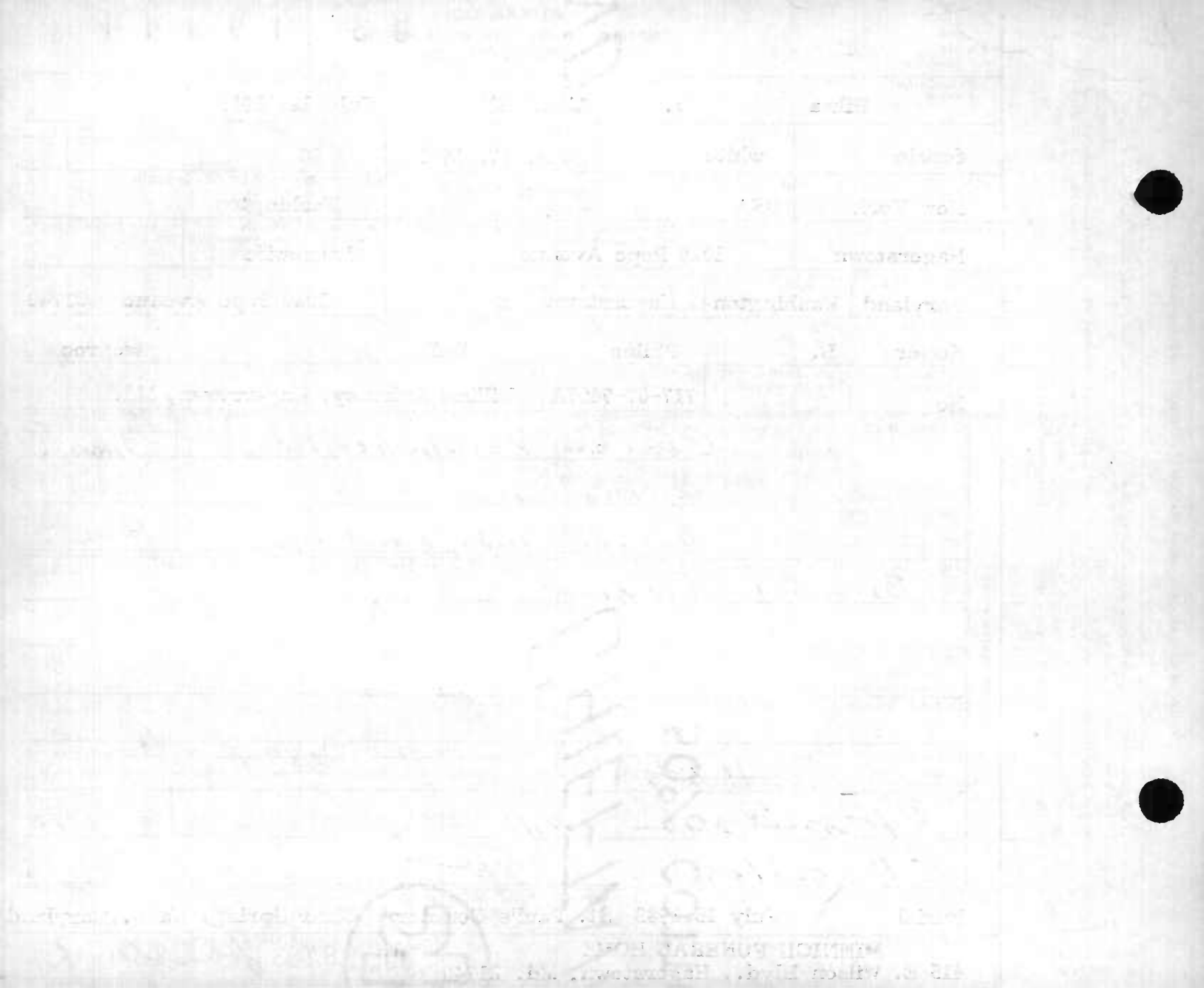
22a. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> , 19 <u>82</u> , to <u>July 12</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11 July</u> , 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <u>E. Hoachlander</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>7/13/83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. Hoachlander</u>		22e. ADDRESS <u>Hagerstown Md.</u>	

23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE <u>July 15, 1983</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Clear Spring, Wash., Maryland</u>
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24. FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>	25a. DATE REC'D. BY REGISTRAR <u>JUL 18 1983</u>	25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

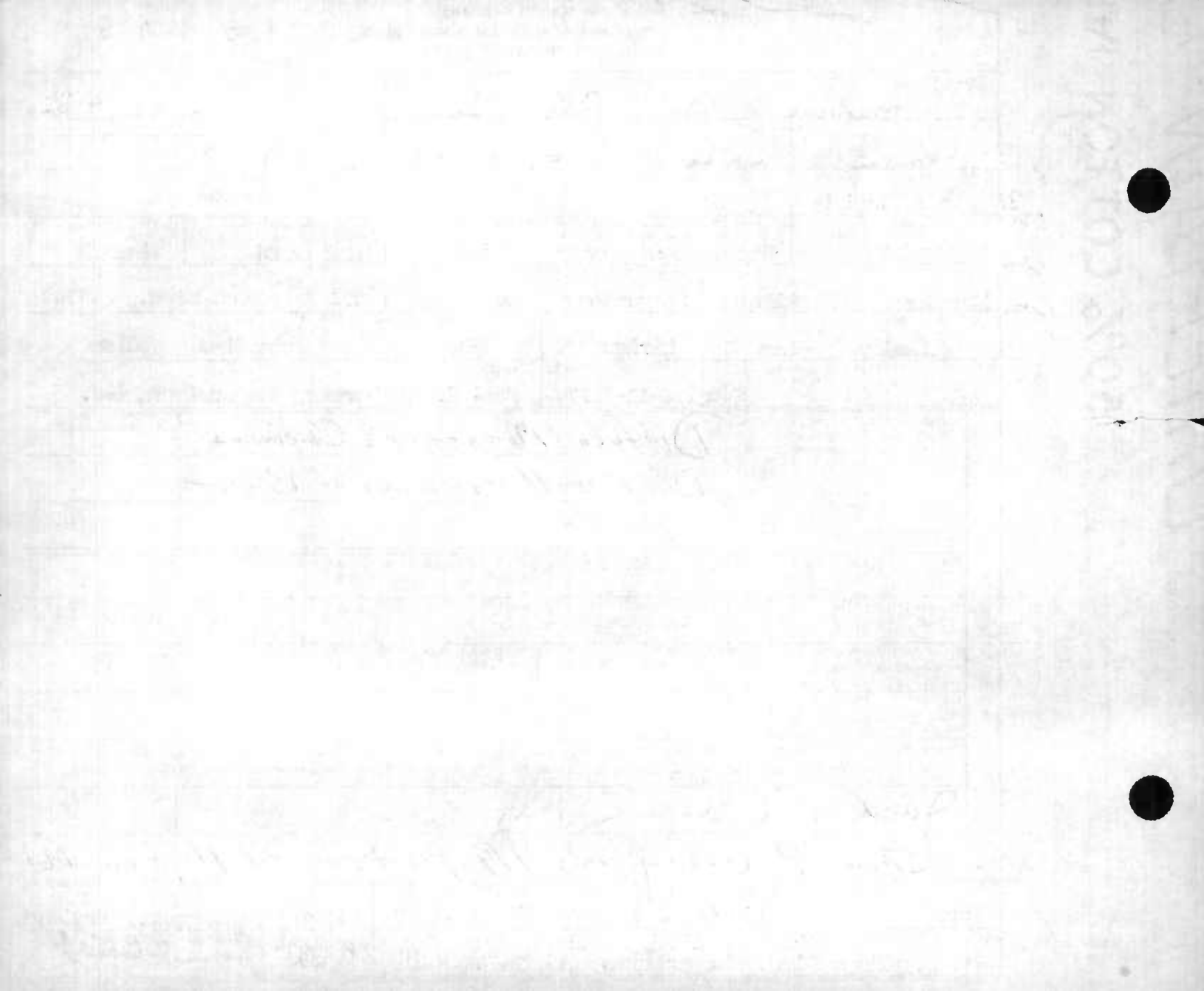
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19845			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Marvella Jean Ausherman				7 22 83 4 40 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		white		May 13, 1924		59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia		USA				Washington MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital		sheet metal		aircraft	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13e. STREET ADDRESS			
Maryland Washington Hagerstown				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 475 Pangborn Blvd. 21740			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Lesley Lee Larison				Ella Jacqueline Clem			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		218-12-5537		Paul E. Ausherman, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Diffuse METASTATIC CARCINOMA							
DUPLICATE OF (b) DUCT CELL CARCINOMA of BREAST							
DUPLICATE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE				22c. DATE SIGNED			
Jack P. Carey, MD							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
JACK P. CAREY, MD				1190 MT Aetna Rd Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
burial		July 25, 1983		Rose Hill Cemetery		Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME				JUL 26 1983		John J. Lohr	
415 E. Wilson Blvd., Hagerstown, Md. 21740							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19846			
1. FOR STATE REGISTRAR				1. DECEASED NAME FIRST MIDDLE LAST Norman Henry Ayers			
2. DATE OF DEATH MONTH DAY YEAR 7 2 83				2b HOUR 4:05 PM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 17, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If nursing home, give street and city) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Car Wash	
13a. STATE Md.				13b. CITY OR TOWN Hagerstown		13c. STREET ADDRESS 210 Potomac Heights 21740	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Ayers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leota Good			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 215-14-1550		17. INFORMANT ADDRESS Mrs. Gladys C. Ayers Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO - RESPIRATORY ARREST</u> <u>3240</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRAIN Abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Lymphoma</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jack P. Carey				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack P. Carey, MD				22e. ADDRESS 1190 Mt. Aetna Rd Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 3, 1983		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION Smithsburg, Wash., Md. STATE	
24. FUNERAL DIRECTOR NAME Davis Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 6 1983			
25b. REGISTRAR'S SIGNATURE John J. Carey							

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "JAN 19" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										19847	
1- FOR STATE REGISTRAR <b>Sadie Alice Baker</b>					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Sadie Alice BAKER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 10 83</b>			2b. HOUR <b>1:00 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 5, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS <b>77</b>		IF UNDER 24 HRS. HOURS MIN. <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co MD.</b>					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Avalon Manor</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laundry</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>					13c. COUNTY <b>Washington</b>		13d. CITY OR TOWN <b>Hagerstown</b>		13e. STREET ADDRESS <b>912 Main Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Turner</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen V. Hitt</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-30-5477</b>		17. INFORMANT ADDRESS <b>James W. Baker 231 Alexander Street Hagerstown, Md. 21740</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4160</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>ASCVD</b> Tarsus died Yas										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>19 82</b> , to <b>7-8</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>7-8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>L. H. Hitt</b> DEGREE						22c. DATE SIGNED <b>7-11-83</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. B. Baker</b>						22e. ADDRESS <b>1933 Va. Ave. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-13-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>						25a. DATE REC'D. BY REGISTRAR OF REGISTRAR'S SIGNATURE <b>JUL 18 1983 John J. Gough</b>					

MEDICAL CERTIFICATION

Sadie Alice Baker

17

June 3, 1908

White

Female

X

U.S.A.

Virginia

Hospital  
21710

January

912 Main Avenue

X

Hagerstown

Washington

Maryland

1911

V.

Ellen

Turner

T.

William

321 Alexander Street  
Hagerstown, Md. 21710

James W. Baker

217-30-5417

- - -

No

Hagerstown, Washington, Md.

Rose Hill Cemetery

7-13-83

Burial

A. A. Cottman Funeral Home, Inc., Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Nora ANN Barr					2a. DATE OF DEATH MONTH DAY YEAR 7-6-83					2b. HOUR 7:45 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1882			6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS			7. UNDER 1 YEAR MONTHS DAYS # UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Funkstown, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD		
10. CITY OR TOWN OF DEATH Boonsboro			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Hm.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 39 N. Main St. 21713		
14. FATHER'S NAME FIRST MIDDLE LAST Fenton Sunan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida F. Harman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-34-0742			17. INFORMANT ADDRESS Mrs. Virginia P. Plaine, 710 Americana Dr. Annapolis, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) <u>Right pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fracture left clavicle</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7 19 81, to 7/5 19 83, that (I) (we) lost saw the deceased alive on 7/5 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. L. Kugler MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 7/7/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. Kugler MD					22e. ADDRESS Geeting Ln. Keedysville Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-9-83		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. Boonsboro, Md. 21713						25a. DATE REC'D. BY REGISTRAR JUL 11 1983			25b. REGISTRAR'S SIGNATURE John J. Lohr		

BP.

John H. Bass, Jr. Boonshoro, Md. 21713  
8-1-1  
7-2-82 Boonshoro Cemetery  
Boonshoro, Md. 21713

No 217-0-015 Mrs. Virginia P. Palmer, Annapolis, Md.  
170 Maryland St.

London  
Boonshoro  
Boonshoro, Md. 21713  
Harris

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Boonshoro, Md. 21713

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detected for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 19849						
1. DECEASED NAME (TYPE OR PRINT) Earl Edward Bennett SR.			2a. DATE OF DEATH 7-12-83			2b. HOUR 7:30 P.M.			
3. SEX male		4. RACE BLACK		5. DATE OF BIRTH 12-6-03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION WESTERN MARYLAND CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME UNKNOWN			15. MOTHER'S MAIDEN NAME UNKNOWN			13e. STREET ADDRESS 440 N. JONATHAN ST. 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-05-2183		17. INFORMANT SR. ADDRESS EARL BENNETT-158 W. North St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>pneumonia, congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>yes</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>stroke &amp; abdominal aortic aneurysm</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6-29-83</u> to <u>7-12-83</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>7/12-83</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input checked="" type="checkbox"/> did not view the body after death.)									
22b. SIGNATURE <u>John P. Palom</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Florescita P. Palom			22e. ADDRESS Western Maryland Center Hagerstown						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/16/83		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.		
24. FUNERAL DIRECTOR NAME <u>Dennis L. Davis</u>			ADDRESS <u>Smithsburg, Md.</u>			25a. DATE REC'D. BY REGISTRAR JUL 18 1983			
25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>									

MEDICAL CERTIFICATION





Page 50-51

Handwritten notes in cursive script, mostly illegible due to fading. Some words like "The" and "and" are visible.

Handwritten notes in cursive script, mostly illegible due to fading. Some words like "The" and "and" are visible.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19850

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Emma S. Bevans			3. DATE OF DEATH MONTH DAY YEAR July 21 1983			2b. HOUR 4:10 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 12 1903		6. AGE YEARS LAST BIRTHDAY 79 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Williamsport			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2750 Virginia Ave. 21795	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Stein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Braun			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-22-2679	
17. INFORMANT ADDRESS 21236			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Brain Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 12</u> , 19 <u>82</u> , to <u>July 21</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.										
22b. SIGNATURE <u>Sidney Novenstein</u>			DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>7/21/83</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SIDNEY NOVENSTEIN</u>			22e. ADDRESS <u>FUNKSTOWN MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/23/83		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR <u>Schamunek Funeral Home, Inc.</u> ADDRESS <u>9705 Belair Rd. Balto. Md. 21236</u>						25a. DATE REC'D. BY REGISTRAR <u>JUL 22 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>		

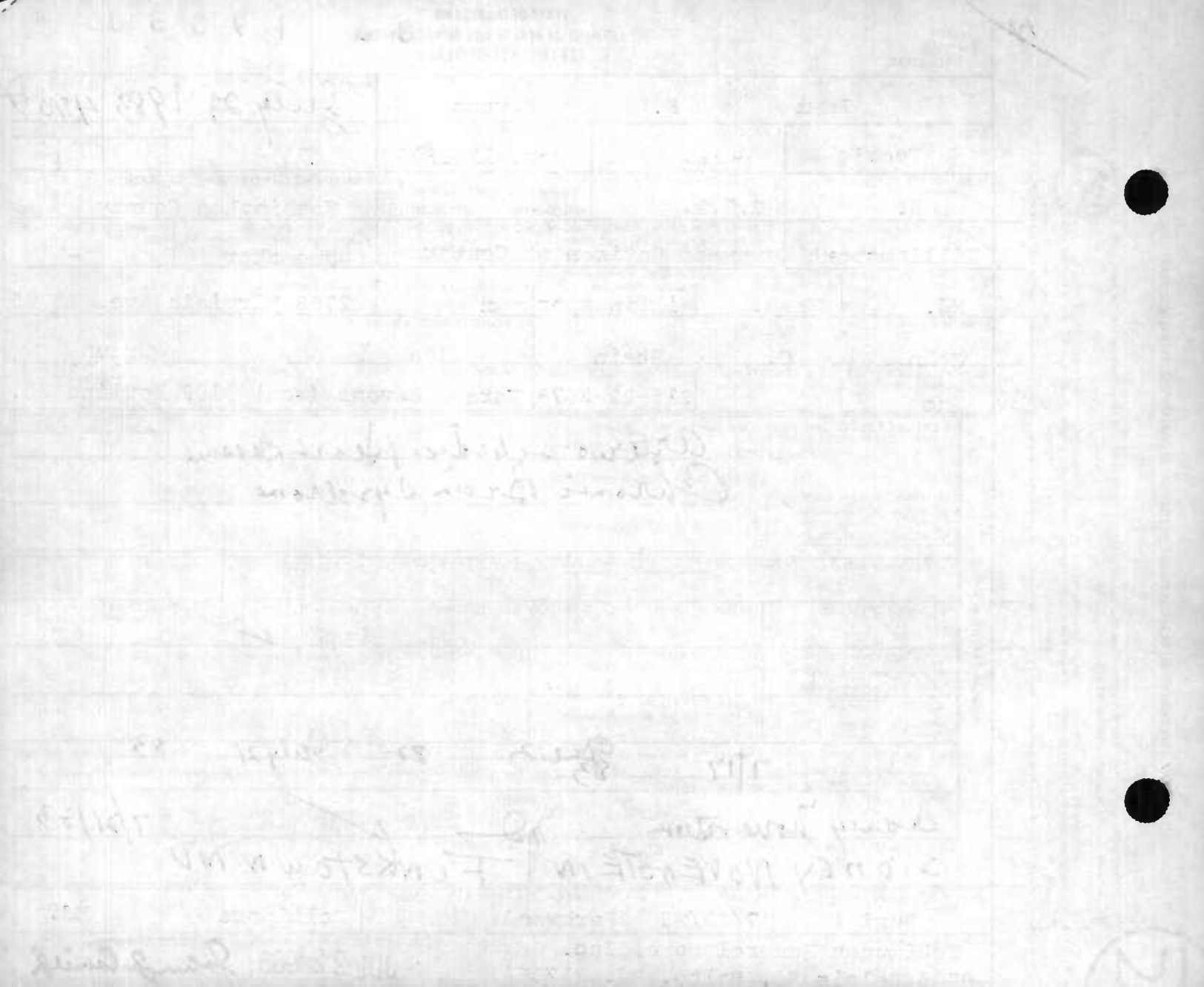
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					19851			
1. FOR STATE REGISTRAR			REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Marlin Henry Boyer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 2 '83</b>		2b. HOUR <b>6:45 a.m.</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 20, 1905</b>		6. AGE (IN YEARS AND BIRTHDAY) <b>78</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shoe Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Boyer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Grubb</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>			16b. SOCIAL SECURITY NO. <b>214-09-5421</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret Boyer, Hagerstown, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Hemisphere CVA</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic cerebral vessel disease</b> (c) <b>Diabetes Mellitus</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Diabetes Mellitus</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital (or) attended the deceased from <b>July 2, 1983</b> to <b>July 2, 1983</b> that (1) (we) last saw the deceased alive on <b>July 2, 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.								
22b. SIGNATURE <b>Robert Brull</b>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Brull</b>		22d. ADDRESS <b>1459 Potomac Ave.</b>		22e. DATE SIGNED <b>7/2/83</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>July 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Millersburg, Pennsylvania</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1983</b>				
				25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>				

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 9 8 5 2

1. DECEASED NAME (TYPE OR PRINT) WILLIAM MELVIN BRANDT			2a. DATE OF DEATH MONTH DAY YEAR July 29 1983			2b. HOUR 6:20A <sub>M</sub>	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 27, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Kauffman Lumber	
						12b. KIND OF BUSINESS OR INDUSTRY Carpenter	
13a. STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Greencastle		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Brandt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Ommert		13e. STREET ADDRESS 117 Walters Ave 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 2nd 43-46		17. INFORMANT Marie H. Brandt 117 Walters Ave. Greencastle Pa			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinomatosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one month	
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the pancreas		3 months	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION June 7 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the pancreas		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) none			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1983, to July 29, 1983, that (I) (we) last saw the deceased alive on July 28, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Francisco G. Japzon, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Jul y 29 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francisco G. Japzon, M.D.				22e. ADDRESS 645 E. First St. Hagerstown, Md. 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/1/1983		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mercersburg, Franklin Penna.	
24. FUNERAL DIRECTOR NAME Harold L. Zimmerman				ADDRESS Greencastle, Pa.		25a. DATE REC'D. BY REGISTRAR AUG 03 1983	
						25b. REGISTRAR'S SIGNATURE Joan E. C... ..	





12



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

THEODORE

F

1. DECEASED NAME  
(TYPE OR PRINT)

THEODORE

F

BUHRMAN

2a. DATE OF DEATH

7-12-83

2b. HOUR 6:00 PM

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

12-21-1919

6. AGE (IN YEARS LAST BIRTHDAY)

63 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

WASHINGTON

MD.

10. CITY OR TOWN OF DEATH

HAGERSTOWN

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
WASH. CO. HOSP.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
FACTORY WORKER

12b. KIND OF BUSINESS OR INDUSTRY

TRUCK ASSEMBLY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MO

13b. COUNTY

WASH.

13c. CITY OR TOWN

SMITHSBURG

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

14209 STOTTLEMEYER RD.

14. FATHER'S NAME

HARRY

MIDDLE

S.

LAST

BUHRMAN

15. MOTHER'S MAIDEN NAME

CLARA

MIDDLE

ISABELLE

LAST

FAVORITE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

220-16-3338

17. INFORMANT

MILDRED BUHRMAN

14209 STOTTLEMEYER RD

SMITHSBURG, MARYLAND

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1539

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Metastatic carcinoma to liver

2 months

(c)

with obstruction + jaundice  
Carcinoma of the colon

2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Renal insufficiency

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from 4-15, 1983, to 7-12, 1983, that (we) lost  
saw the deceased expire on 7-12, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated  
above. (If not, did not view the body after death.)

22b. SIGNATURE

ROBERT J. TRACE, M.D.

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

7-12-83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

HAGERSTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

7-16-83

23c. NAME OF CEMETERY OR CREMATORY

BLUE RIDGE CEMETERY

23d. LOCATION

CITY OR TOWN  
THURMONTCOUNTY  
FREDERICKSTATE  
MD

24. FUNERAL DIRECTOR

DAILEY'S FUNERAL HOME

615 E. MAIN

THURMONT

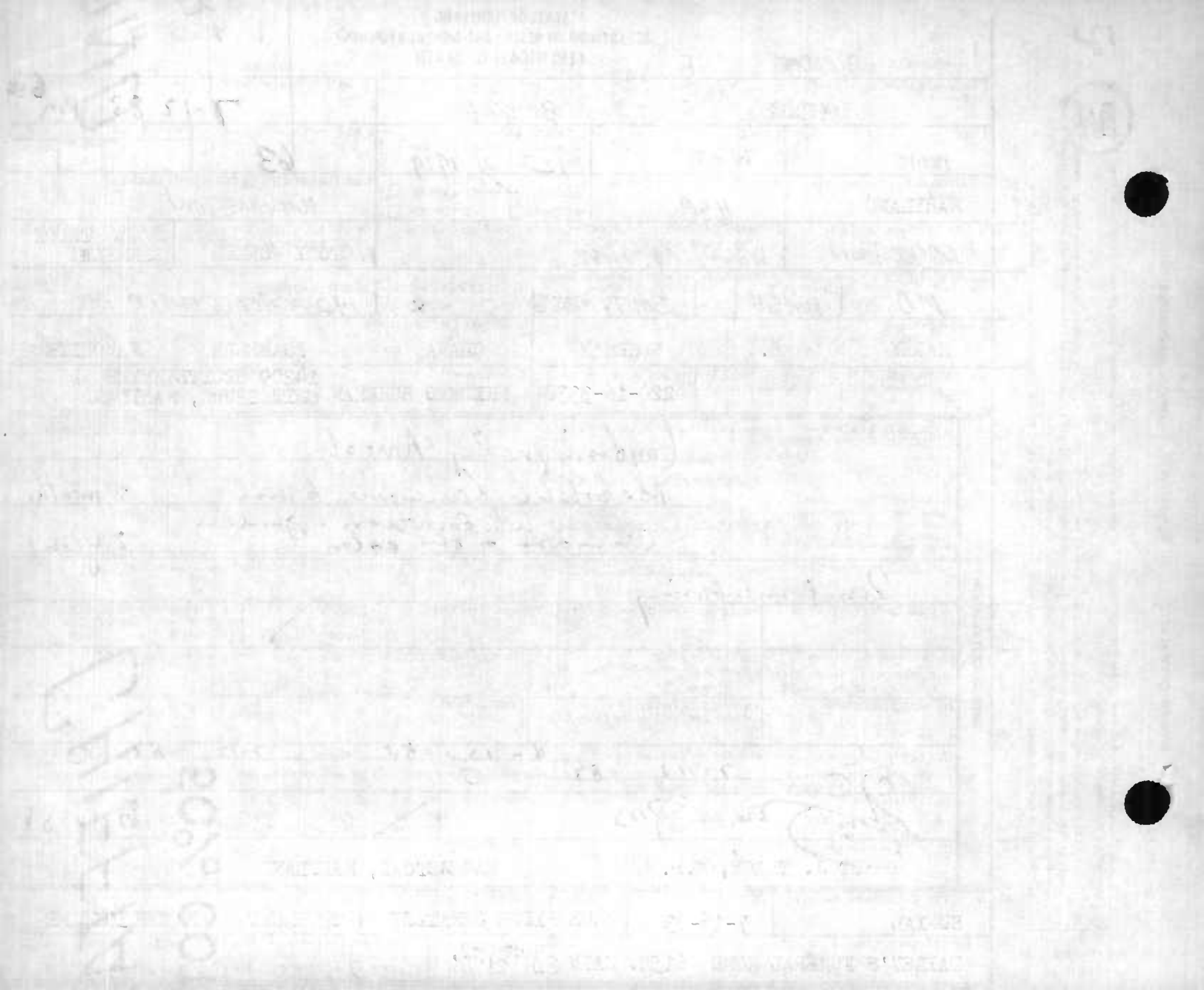
MD 21788

25a. DATE REC'D. BY REGISTRAR

JUL 26 1983

25b. REGISTRAR'S SIGNATURE

J. E. Carrel



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19854

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LLOYD H BURGER			2a. DATE OF DEATH MONTH DAY YEAR 7 24 83		2b. HOUR 9:57 P M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 10 16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY hand tools
13a. STATE MD.	13b. COUNTY WASH.	13c. CITY OR TOWN HAG.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1145 POTOMAC AVE 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Burger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Stephanie K. Burger 1145 Potomac Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR. 10 YES.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): RENAL FAILURE, HYPERTENSION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ali Raza		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELI ROZA		22e. ADDRESS WASHINGTON COUNTY HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Parklawn's Mem Gardens Chambersburg Pa.	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR JUL 27 1983		25b. REGISTRAR'S SIGNATURE John E. B...	
415 E. Wilson Blvd. Hagerstown, Md. 21740					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 11 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

Handwritten notes and a table on lined paper. The table has several columns and rows of data, though the text is mostly illegible due to fading and bleed-through. Some visible words include "Total", "Average", and "Standard".

Handwritten notes and a table on lined paper. The table has several columns and rows of data, though the text is mostly illegible due to fading and bleed-through. Some visible words include "Total", "Average", and "Standard".



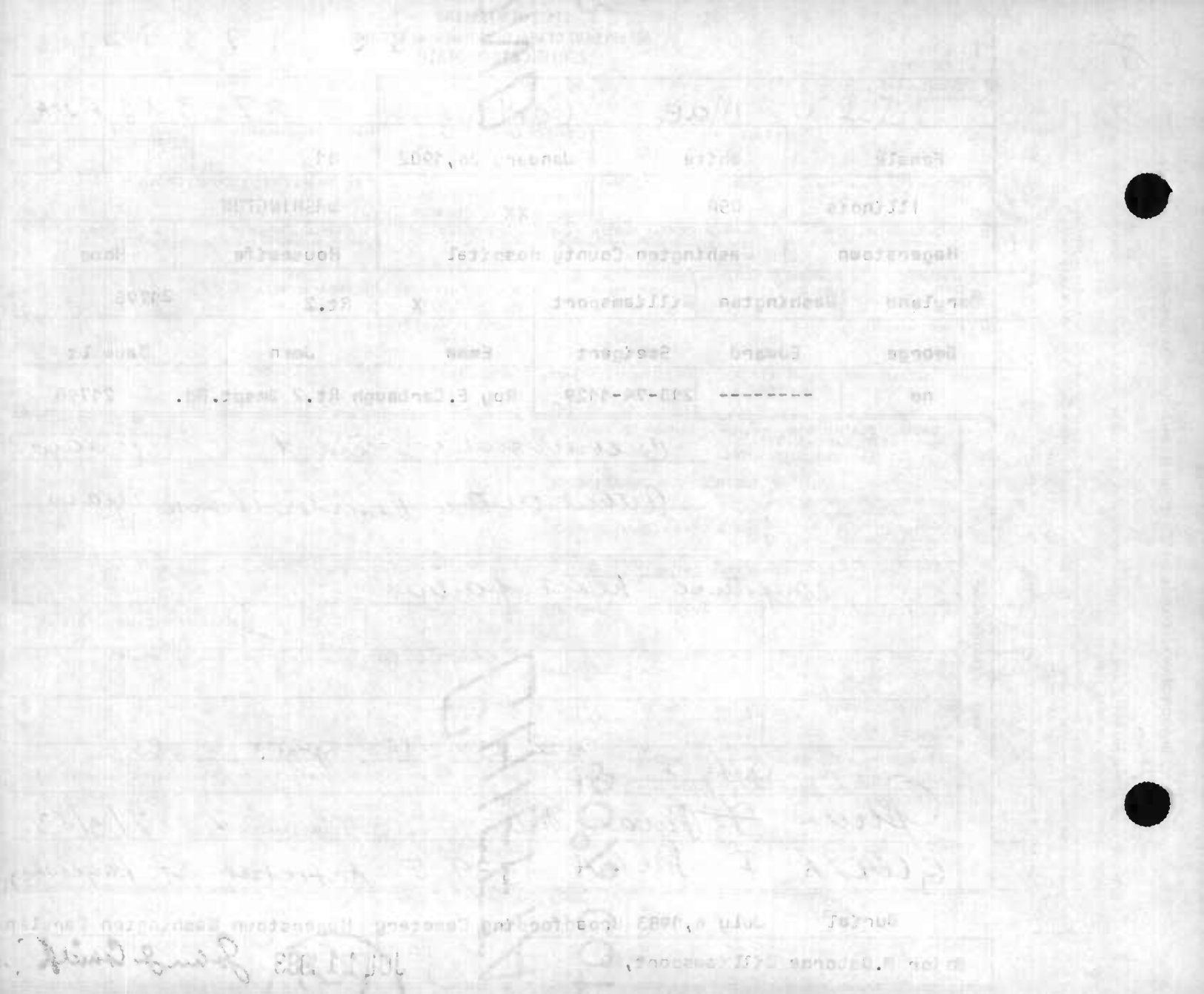
20% COFFEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				19855			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Julia Mae Carbaugh</u>				2a. DATE OF DEATH MONTH <u>7</u> DAY <u>3</u> YEAR <u>83</u> 2b. HOUR <u>4:23A</u> M			
3 SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>January</u> DAY <u>26</u> YEAR <u>1902</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Illinois</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>WASHINGTON</u> MD.	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Washington</u> 13c. CITY OR TOWN <u>Williamsport</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Rt. 2</u> <u>21795</u>	
14. FATHER'S NAME FIRST <u>George</u> MIDDLE <u>Edward</u> LAST <u>Sweigert</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Emma</u> MIDDLE <u>Jean</u> LAST <u>Day</u> <u>1t</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>213-74-1129</u>		17. INFORMANT ADDRESS <u>Roy E. Carbaugh Rt. 2 Wmspt. Md. 21795</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4360</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Vascular Disease</u> years DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>congestive heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 23</u> 19 <u>83</u> to <u>July 3</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Gloria F. Pura</u> DEGREE <u>MD.</u>				22c. DATE SIGNED <u>7/3/83</u>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GLORIA F. PURA</u>				22f. ADDRESS <u>339 E. Antietam St. Hagerstown</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>July 6, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Broadfording Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Hagerstown</u> COUNTY <u>Washington</u> STATE <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>Major M. Osborne Williamsport, MD</u>				25a. DATE REC'D BY REGISTRAR <u>JUL 11 1983</u> REGISTRAR'S SIGNATURE <u>John J. Conish</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 19856	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Verna Edna CARR</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 16, 1983</b>			2b. HOUR <b>10:45P<sub>M</sub></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 9, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Morgan Co. W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Homewood Retirement Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4 Knode Circle</b>		21713	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Clark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy F. Luttrell</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>			
16b. SOCIAL SECURITY NO. <b>214-14-6620</b>				17. INFORMANT ADDRESS <b>4 Knode Circle</b>				17. Mr. Leon L. Carr, Jr. Boonsboro, Md. 21713			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dissecting Aneurysm of Aorta</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dissecting Aneurysm of Aorta</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/16 7:16 P.M. 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>7/16</b> 19 <b>83</b> , to <b>7/16</b> 19 <b>83</b> , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sidney Moverstein</b> DEGREE						22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>7/16/83</b>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SIDNEY MOVERSTEIN</b>						22f. ADDRESS <b>FUNKSTOWN MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-19-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Funkstown Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Funkstown, Wash. Co., Md.</b>				
24. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr.</b>						24. ADDRESS <b>Boonsboro, Maryland 21713</b>		25a. DATE REC'D. BY REGISTRAR <b>22 1983</b> REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

BP

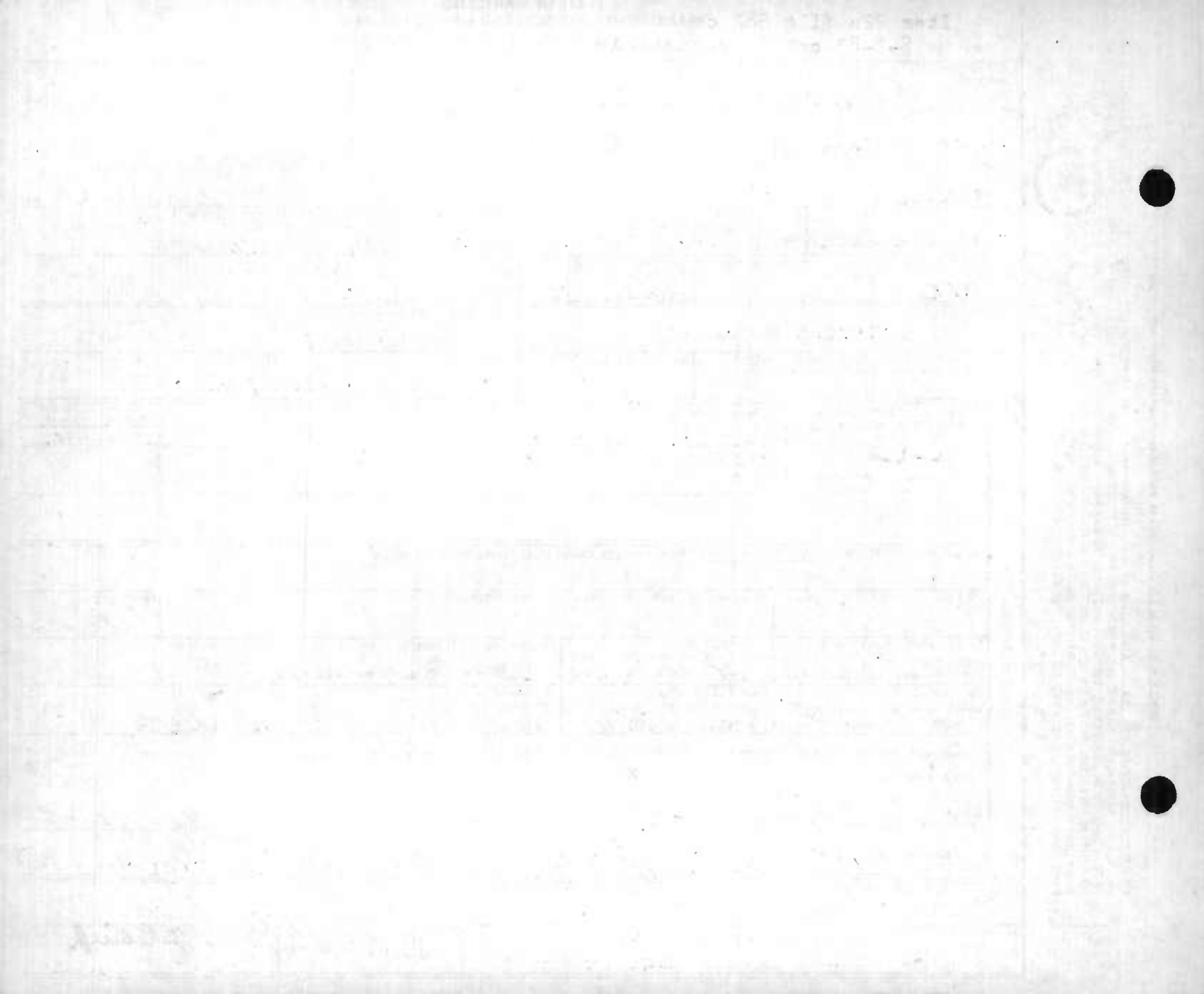


John F. Smith, Jr., Secretary, 2215 17th St., N.W., Washington, D.C. 20036

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR Item 22a film 582 DEPARTMENT OF HEALTH AND MENTAL HYGIENE										1 9 8 5 7					
1- STATE REGISTRAR 8-2-83 cn MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Salvador Sanchez Colmenero</b>						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <b>July 2 19 83</b>		2b. HOUR <b>2:00 PM</b>		2c. DATE PRONOUNCED DEAD <b>July 2 19 83</b>					
3. SEX <b>male</b>	4. RACE <b>Hispanic</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>14</b> YEAR <b>59</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>23</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Ct. MD.</b>		2d. HOUR <b>5:00 PM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>5 Mexico</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Mexico</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>near Shepardstown, W.Va. Potomac river</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>migrant worker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
10. CITY OR TOWN OF DEATH <b>near Shepardstown</b>						13a. STATE <b>NC</b>		13b. COUNTY <b>Reidsville</b>		13c. CITY OR TOWN <b>Reidsville</b>					
14. FATHER'S NAME FIRST <b>Salvador</b> MIDDLE <b>Colmenero</b> LAST <b>Colmenero</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Gueda</b> MIDDLE <b>Lute</b> LAST <b>Lute</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Vera Kinton, Reidsville, N.C.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9102</b> IMMEDIATE CAUSE (a) <b>Drowning</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:00 PM 7 2 1983</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Was swimming</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Potomac River</b>				21f. LOCATION STREET <b>near Shepardstown</b> CITY OR TOWN <b>WVA</b> COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <b>Allen W.D. H. M.D.</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>7/2/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Allen W.D. H. M.D.</b>				ADDRESS <b>1610 Oak Hill Ave. Hagerstown MD</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>removal</b>				23b. DATE <b>July 12, 1983</b>				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN <b>Reidsville, N.Car.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Minnich Funeral Home</b>				ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19858			
1. DECEASED NAME (TYPE OR PRINT) <b>John max Cramer</b>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <b>July 1 1983 11:25 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 13 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>143 N. Cannon Avenue</b>		13f. STREET ADDRESS <b>21740</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Albertus Cramer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Catherine Plummer</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW I 716-03-2093</b>		17. INFORMANT ADDRESS <b>Fern D.C. Myerly 950 Jefferson Blvd. Hag. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hrs</b> <b>normal</b> <b>young</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Previous episode of pulmonary edema + congestive heart failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 30 1982</b> , to <b>July 1 1983</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>June 30 1982</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>not</del> ) view the body after death.							
22b. SIGNATURE <b>Edward S. Hardy</b>				22c. DATE SIGNED <b>7/6/83</b>		22d. ADDRESS	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gerald N. Minnich</b>				22f. ADDRESS <b>Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-6-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery Hagerstown Wash. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>		24b. ADDRESS <b>305 N. Potomac St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19859			
1. DECEASED NAME (TYPE OR PRINT) <b>Walter Davis Cunningham</b>				2a. DATE OF DEATH MONTH DAY YEAR 7 26 83			
3. SEX <b>Male</b>				2b. HOUR 2:30 A.M.			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR 2 11 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Washington County</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Wash. County</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Webster Cunni ngham</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ni na May Koontz</b>		13e. STREET ADDRESS <b>42 EAST AVE.</b>		2740	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-32-5621</b>		17. INFORMANT <b>Laura Cunningham</b>		ADDRESS <b>42 East Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1850</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1850</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>7/25</b> , 19 <b>83</b> , to <b>7/26</b> , 19 <b>83</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>7/25</b> , 19 <b>83</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did)</del> (did not) view the body after death.							
22b. SIGNATURE <b>George Newman II M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		23d. LOCATION <b>Hagerstown, Wash. Md. STATE</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 01 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Sam J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19860			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) CHARLES ADAM DECK LAST Deck				2b. HOUR A 3:40 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10/31/1918		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greencastle, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tooling		12b. KIND OF BUSINESS OR INDUSTRY Mfg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 21740 1044 Pennsylvania Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Harrison Deck				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Pearl "Bentz"			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW2 160-16-8346		17. INFORMANT ADDRESS Aleiece E. Deck/same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARBON RESPIRATORY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL METASTASIS } DUE TO, OR AS A CONSEQUENCE OF (c) SMALL CELL CARCINOMA OF LUNG							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that (1) (this hospital) attended the deceased from 19 to 19, that (1) (we) lost saw the deceased die on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (do) (do not) view the body after death.							
22a. SIGNATURE [Signature] DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/25/83	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) C. WOOSTER				22d. ADDRESS 1825 Howell RD HAGERSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/27/83		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown, Wash. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc. 1601 Penna. Ave. Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 28 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

## APPENDIX

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19861

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Aaron Christian DELAUNEY			2a. DATE OF DEATH MONTH DAY YEAR July 5, 1983		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR March 10, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Storage Operator		12b. KIND OF BUSINESS OR INDUSTRY Cement Co.
13a. STATE Md.			13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Aaron B. DelauneY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elnora V. Grove		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-1598		17. INFORMANT ADDRESS Mrs. Mary E. DelauneY Hagerstown, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Chronic Obstr. Pulm. Dis., GI bleeding, Multiple Myeloma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1983</u> to <u>July 5, 1983</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (us) did not view the body prior to death.			
22b. SIGNATURE [Signature]	DEGREE [Degree]	22c. DATE SIGNED 5 July 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Binterd		22e. ADDRESS Hagerstown, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 9, 1983	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash, Md.
24. FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home Hagerstown, Md.		25. DATE REC'D. BY REGISTRAR JUL 11 1983	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				19862			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Thomas Stanley Demboski				2a. DATE OF DEATH MONTH DAY YEAR 7/1/83			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Maint.		12b. KIND OF BUSINESS OR INDUSTRY Mack Truck	
13a. STATE Maryland				13b. COUNTY Washington			
13c. CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Stanley Demboski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Popolski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 154-14-3928			
17. INFORMANT Genevieve V. Demboski Same as #13				ADDRESS 1006 Potomac Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> minutes DUE TO, OR AS A CONSEQUENCE OF (c) <u>Previous myocardial infarction and congestive heart failure</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Previous myocardial infarction and congestive heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>April</u> , 19 <u>83</u> , to <u>July</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive <u>in June</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Alan W. Ditt</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan W Ditt MD				22e. ADDRESS 1610 Oak 14 Ave Hagerstown MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-7-83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION CITY OR TOWN COUNTY STATE S. Plainfield M.D.	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland				25a. DATE REC'D. BY JUL 11 1983			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR July 7, 1983		2b. HOUR 3:15 AM	
1. DECEASED NAME (TYPE OR PRINT) Oliver Clay DENNIS		3. SEX male		4. RACE white	
5. DATE OF BIRTH MONTH DAY YEAR January 23, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	
8. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		10. CITY OR TOWN OF DEATH Hagerstown	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 317 Daycotah Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY City Gov.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 317 Daycotah Ave. 21740			
14. FATHER'S NAME FIRST MIDDLE LAST George F. Dennis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie V. Simpson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 219-12-1634		17. INFORMANT Enid V. Toms, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Obstructive Pulmonary disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/18/83</u> , 19 <u>83</u> , to <u>7/17/83</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>7/16/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert V. Campbell MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robt. V. Campbell MD</u>		22e. ADDRESS <u>Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Hagerstown, Wash., Maryland		24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
25a. DATE REC'D. BY REGISTRAR JUL 12 1983		REGISTRAR'S SIGNATURE <u>John J. Casper</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Goldie MARIE Diehl</b>										2a. DATE OF DEATH MONTH <b>7</b> DAY <b>27</b> YEAR <b>83</b> 2b. HOUR <b>2:55 P.M.</b>									
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH <b>June</b> DAY <b>23</b> YEAR <b>1902</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.										
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>										
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Washington</b>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS <b>Rt. 1 Box 41S 21750</b>										
14. FATHER'S NAME FIRST <b>Wilson</b> MIDDLE <b></b> LAST <b>Clineman</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Pauline</b> MIDDLE <b></b> LAST <b>Smith</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218 30 8806</b>			17. INFORMANT ADDRESS <b>Vera G. Michael Rt#1 Box 36S Hancock, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6d</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Vascular Disease</b>										DUE TO, OR AS A CONSEQUENCE OF (c) <b>yes</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Congestive Heart Failure</b>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <b>6-17</b> , 19 <b>76</b> , to <b>7-27</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>7-27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																			
22b. SIGNATURE <b>James Michael Jr</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7-27-83</b>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-30-1983</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Christian</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Artemas Bedford Penna.</b>										
24. FUNERAL DIRECTOR NAME <b>Richard D. Grove</b>			ADDRESS <b>Hancock MD.</b>			25. DATE REC'D. BY REGISTRAR <b>AUG 8 1983</b>			25. REGISTRAR'S SIGNATURE <b>John J. Smith</b>										

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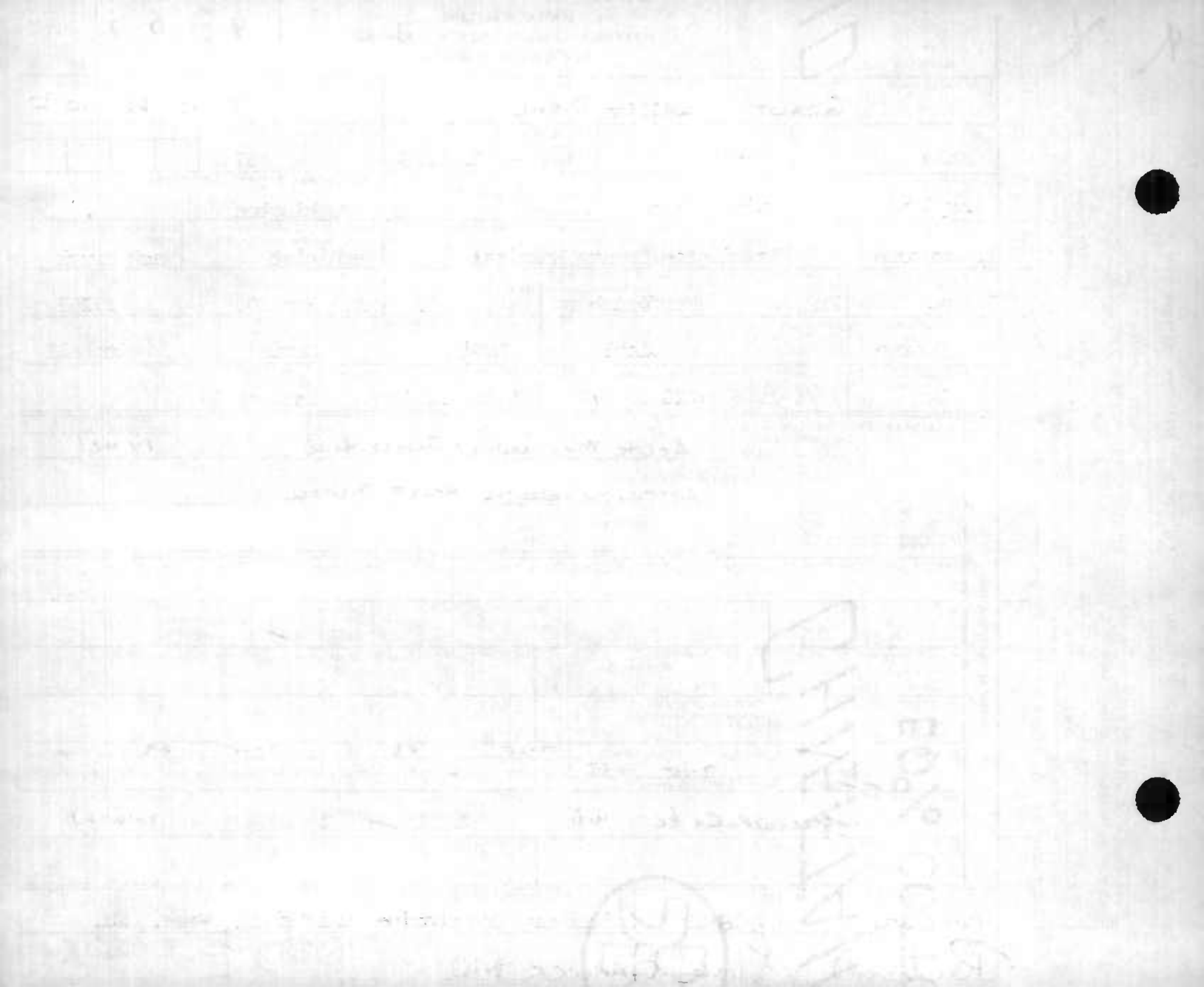
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) GRANT William Diehl					2a. DATE OF DEATH MONTH DAY YEAR 7 15 83		2b. HOUR 10 <sup>PM</sup> M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 22, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Mack Truck		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna.					13b. COUNTY Fulton		13c. CITY OR TOWN Warfordsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	
14. FATHER'S NAME FIRST MIDDLE LAST George Diehl					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Marie Mitchell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 1945-1946 220 09 7722		17. INFORMANT ADDRESS Vivian R. Diehl Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a). Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 HRS										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 7-15 19 83, to 7-16 19 83, that (I) (we) last saw the deceased alive on 7-15 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE J. H. Hancock MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-16-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 7-18-83		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. Md.			
24. FUNERAL DIRECTOR Richard J. Lane					25a. DATE RECEIVED BY REGISTRAR USE REGISTRAR SIGNATURE JUL 25 1983 John J. Lane					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										1986	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edith Hadassa Dieterich					2a. DATE OF DEATH MONTH DAY YEAR July 28, 1983			2b. HOUR 105AM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR August 22, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route #4 21740			
14. FATHER'S NAME FIRST MIDDLE LAST John H. Shank				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Downey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-42-1951		17. INFORMANT ADDRESS Lena Mae Myers Rt. #4 Box 219 C					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Multiple System Failure DUE TO, OR AS A CONSEQUENCE OF (b) Intoxication (Alcohol) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple Decubitus ulcers with infection										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1980 to 28 July 1983, that (I) (we) lost saw the deceased alive on 27 July 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W.M. Fender					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 29 July 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.M. Fender					22e. ADDRESS 138 E. Antietam St Hagerstown MD 21740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Lutheran Cem. Fairview		23d. LOCATION CITY OR TOWN COUNTY STATE Washington Md.				
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR AUG 02 1983		25b. REGISTRAR'S SIGNATURE C. E. G. G. G.				
415 E. Wilson Blvd. Hagerstown, Md. 21740											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19867			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Martha Dorothy EATON</b>				July 17, 1983			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 23, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. STREET ADDRESS <b>438 Salem Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Othie J. Eaton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha E. Boyers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Betty Jane Shipley, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b> <b>10 - 15 YRS.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the deceased) attended the deceased from <b>DECEMBER 13, 1980</b> to <b>MAY 11, 1983</b> , that (I) (we) lost <b>saw the deceased alive on MAY 11, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Edward W. Ditto</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>JULY 18, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>				22e. ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>July 19, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sharpsburg, Wash., Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 26 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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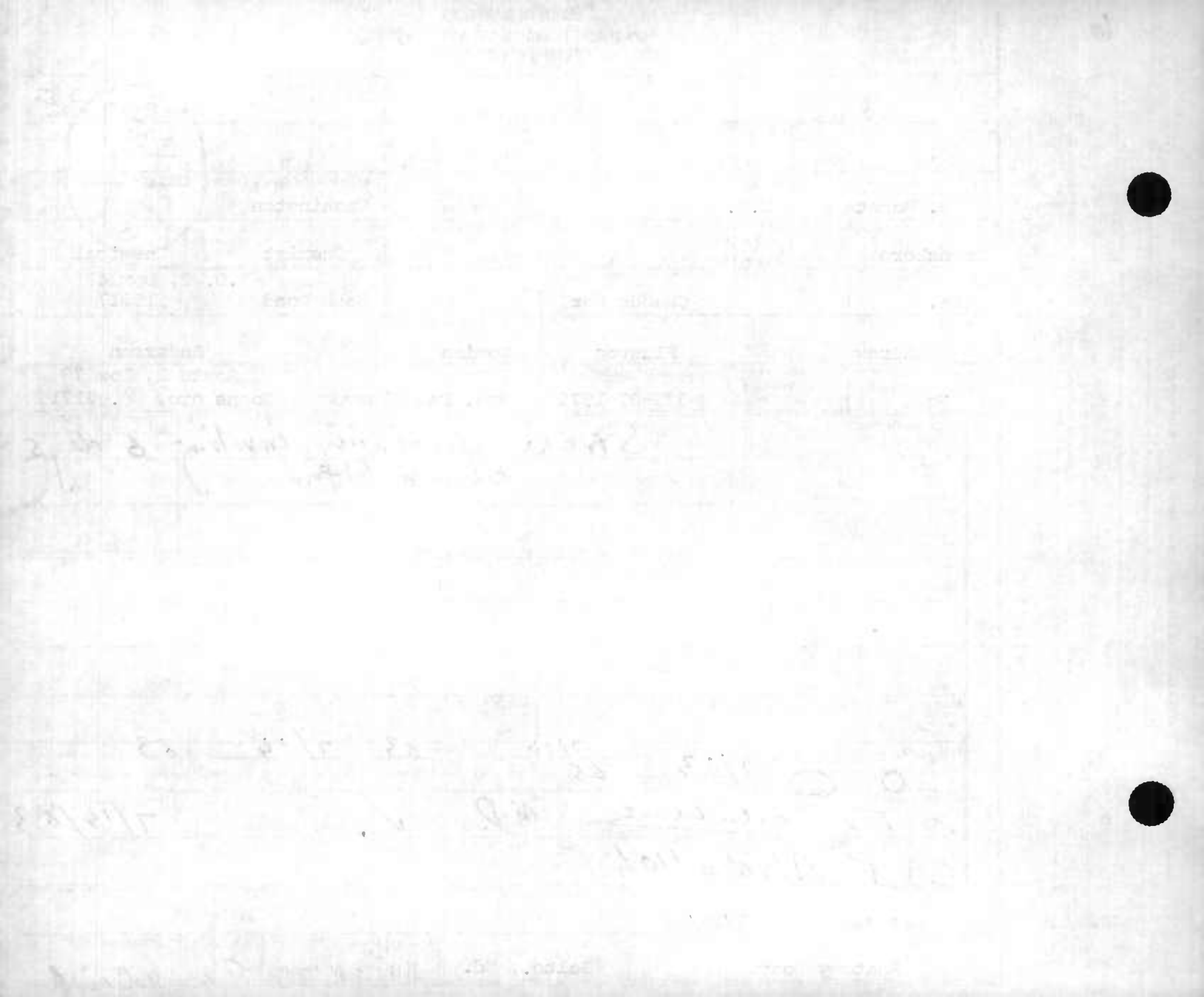
**• L. J. FILL, EDITOR •**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										19868	
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Edwin A Fluevog					2a. DATE OF DEATH MONTH DAY YEAR 7 14 83			2b. HOUR 6:25 AM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 4 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Tabney Keedy Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY Chemical			
13a. STATE Pa.		13b. COUNTY		13c. CITY OR TOWN Chadds Ford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Webb Road		R.D. 2, Box 49 1931799999	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Fluevog					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tomina Anderson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 385-07-1975		17. INFORMANT Mrs. Fae Fluevog		ADDRESS Route 2, Box 78 Boonsboro, Md. 21713					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Stroke probably involving brain stem. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/10 1983 to 7/14 1983, that (I) (we) lost saw the deceased at 7/13 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. F. Abdullah				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. F. Abdullah				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 7/15/83		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUL 18 1983		25b. REGISTRAR'S SIGNATURE John J. Condit			

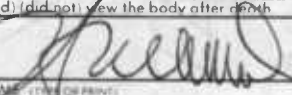



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IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner or licensed observer.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR		Item 18b & c film 583		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 1 9 8 6 9	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OLIVE Clhorene FORD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 10, 1983</b>		2b. HOUR <b>5:25 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 6, 1899</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>83</b> IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Clearspring, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AVALON MANOR NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>324 N. Main St.</b>		13f. CITY OR TOWN <b>21713</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>John Alfred Hose</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Elizabeth Harsh</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-20-8434</b>		17. INFORMANT ADDRESS <b>Robert E. Ford, 1933 Stone Valley Dr. Hagerstown, Md. 21740</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Septicemia from chronic draining hip wound</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Marked inanition &amp; malnutrition</b> <b>Weeks</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease</b> <b>year</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Arteriosclerotic disease</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 1980 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>no recent injury</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>unknown</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>unknown</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>on call for Dr. Ditto III</b> , 19____, that (I) (we) lost saw the deceased alive on <b>above</b> , 19____, and that in <b>Natural</b> death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE <b>Attending Physician</b>		MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/11/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HOWard N. Weeks, M.D.</b>		22e. ADDRESS <b>580 Northern Avenue Hagerstown, Md. 21740</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			
23b. DATE <b>7-13-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr.</b>		ADDRESS <b>Boonsboro, Maryland 21713</b>		25. DATE REC'D BY REGISTRAR <b>JUL 14 1983</b>		25. REGISTRAR'S SIGNATURE 	



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#46, Film G582 8/4/83 kam

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

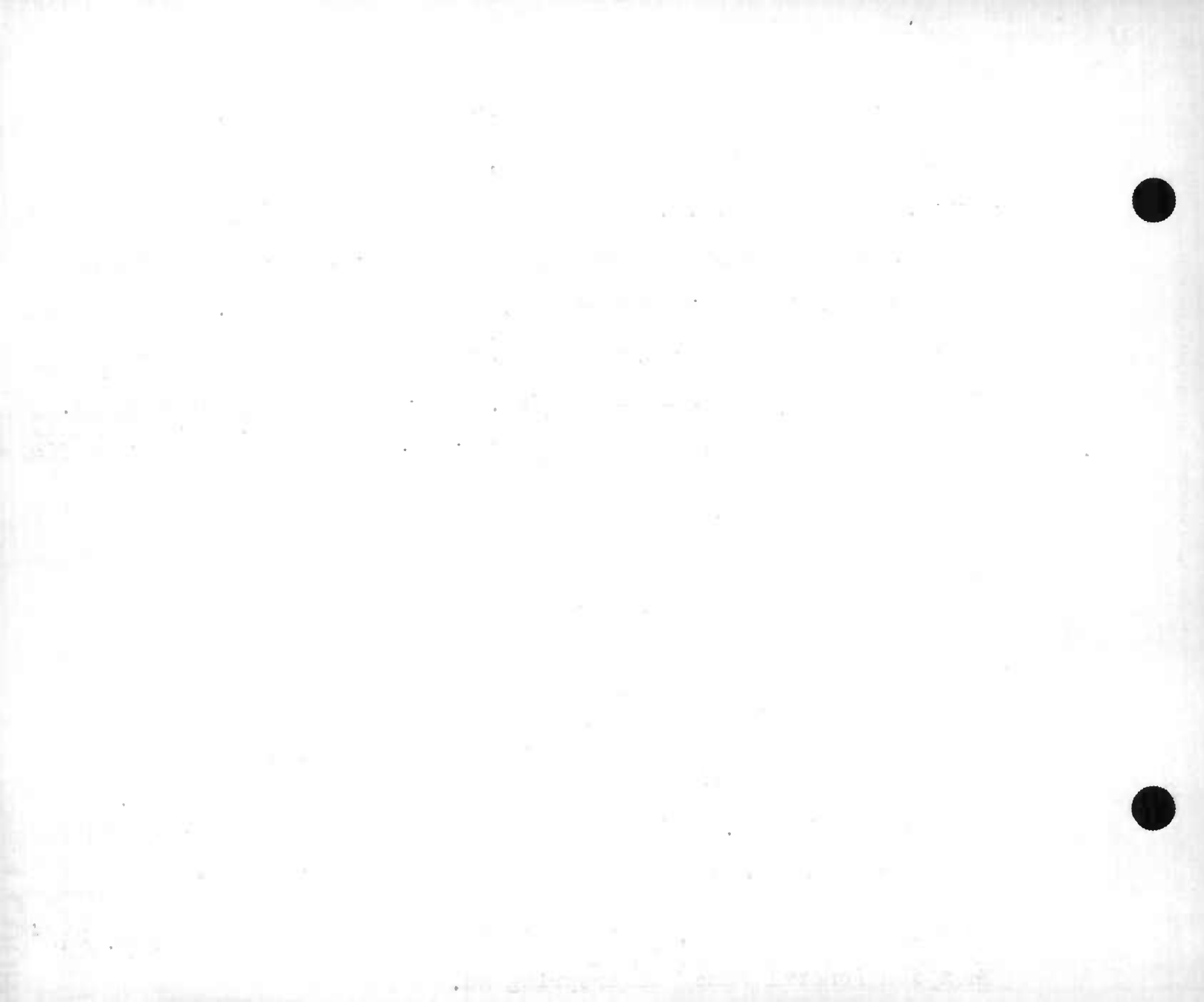
REG. NO.

1 9 8 7 0

1 DECEASED NAME (TYPE OR PRINT) <b>Lulu Edna Funkhouser</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 16, 1983</b>			2b. HOUR M <b>AM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 29, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>96 95</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clearview Nursing</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Clearspring</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>109 Main St.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Franklin Clopper</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elva Shank</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-46-6174</b>		17 INFORMANT ADDRESS <b>Mrs. Lillian Cook Clearspring Md.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast with metastases</b> <b>1455</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19, 83</b> to <b>16 July 19 83</b> , that (I) (we) last saw the deceased alive on <b>14 July 19 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)									
22b. SIGNATURE <b>J.D. Wilson, M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7/18/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.D. Wilson, M.D.</b>			22e. ADDRESS <b>580 Northern Ave, Hagerstown, MD 21740</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 19, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blairs Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clearspring 3, Caroline</b>		
24. FUNERAL DIRECTOR <b>Thompson Funeral Home Clearspring Md.</b>									

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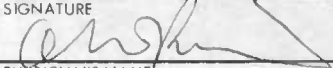





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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										1987	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>MABEL GAINES</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>7 3 83</b>		2b. HOUR <b>11:00</b> P M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 21 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>224 Summit Ave. 21740</b>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>				16b. SOCIAL SECURITY NO. <b>214-09-4450</b>		17. INFORMANT ADDRESS <b>Route 2, Hollywood Drive Mr. William S. Hurd Raymond, N. H. 03077</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOXIC ENCEPHALOPATHY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <b>CARDIAC ARREST</b> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6-30-83</b> , to <b>7-3-83</b> , that (I) (we) last saw the deceased alive on <b>7-3-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7.4.83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OTTO ROZA</b>				22e. ADDRESS <b>100 LONG HEADEN DRIVE HAGERSTOWN</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>7/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1983</b>		25b. REGISTRAR'S SIGNATURE 			

WASHINGTON, D.C.

UNITED STATES

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D.C.

ADJUTANT GENERAL

ADJUTANT GENERAL



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19872

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy Grace Gardner</i>			2a. DATE OF DEATH MONTH DAY YEAR July 6, 1983			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 22, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Washington</i> 13c. CITY OR TOWN <i>Williamsport</i> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>Rt. 2 Box # 276 21795</i>								
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Earl Kaetzel</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edna Lavine Hartle</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-12-1974</i>		17. INFORMANT ADDRESS <i>Thomas J. Gardner (item 13 above)</i>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

1809

IMMEDIATE CAUSE (a)

*Renal failure*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*2 months*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*advanced metastatic squamous cell**1 year*

DUE TO, OR AS A CONSEQUENCE OF

(c)

*carcinoma of cervix with invasion of kidney*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7-9-83</i> , 19 <i>83</i> , to <i>7-6-83</i> , 19 <i>83</i> , that (I) <i>(was)</i> last saw the deceased alive on <i>7-6-83</i> , 19 <i>83</i> , and that in (my) <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(did)</i> (did not) view the body after death.							
22b. SIGNATURE <i>John J. Scantini</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7-7-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>July 9, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown Washington Maryland</i>	
24. FUNERAL DIRECTOR <i>Major M. Osborne Williamsport, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 12 1983</i> 25b. REGISTRAR'S SIGNATURE <i>John J. Scantini</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Arlington L Giff</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 11 83</b>		2b. HOUR <b>6:40 P M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 11, 1916</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>66</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Samples Manor, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>County Parks</b>
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Keedysville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mayberry Giff</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Ellen Holmes</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-03-9819</b>		17. INFORMANT ADDRESS <b>Rfd. 1 Box 168</b>
17. INFORMANT <b>Mrs. Georgetta E. Giff, Keedysville, Md.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse Histocyte Lymphoma</b> <b>2000</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 mo</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/11/83</b> to <b>7/11/83</b> , that (I) (we) lost saw the deceased alive on <b>7/11/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Frederic H. Kross III</b>	DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>7/13/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic H. Kross III</b>	22e. ADDRESS <b>1825 Howell Rd Hagerstown Md</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7-14-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery Samples Manor, Wash. Co., Md.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr. Boonsboro, Maryland 21713</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

Male

White

Sept. 11, 1915

55

Samuel Mann, No. 1, 2, 3.

Samuel Mann

Highway

Washington County Hospital

County

County Parks

Highway

Washington County Hospital

A

121.7 Box 108 2155

Highway

Highway

Highway

Highway

Highway

215-00-2015

215-00-2015 215-00-2015 215-00-2015 215-00-2015 215-00-2015

Samuel Mann

1-11-15

Samuel Mann Cemetery, Samuel Mann, No. 1, 2, 3.

John H. Best, Jr. 215-00-2015 215-00-2015 215-00-2015 215-00-2015 215-00-2015

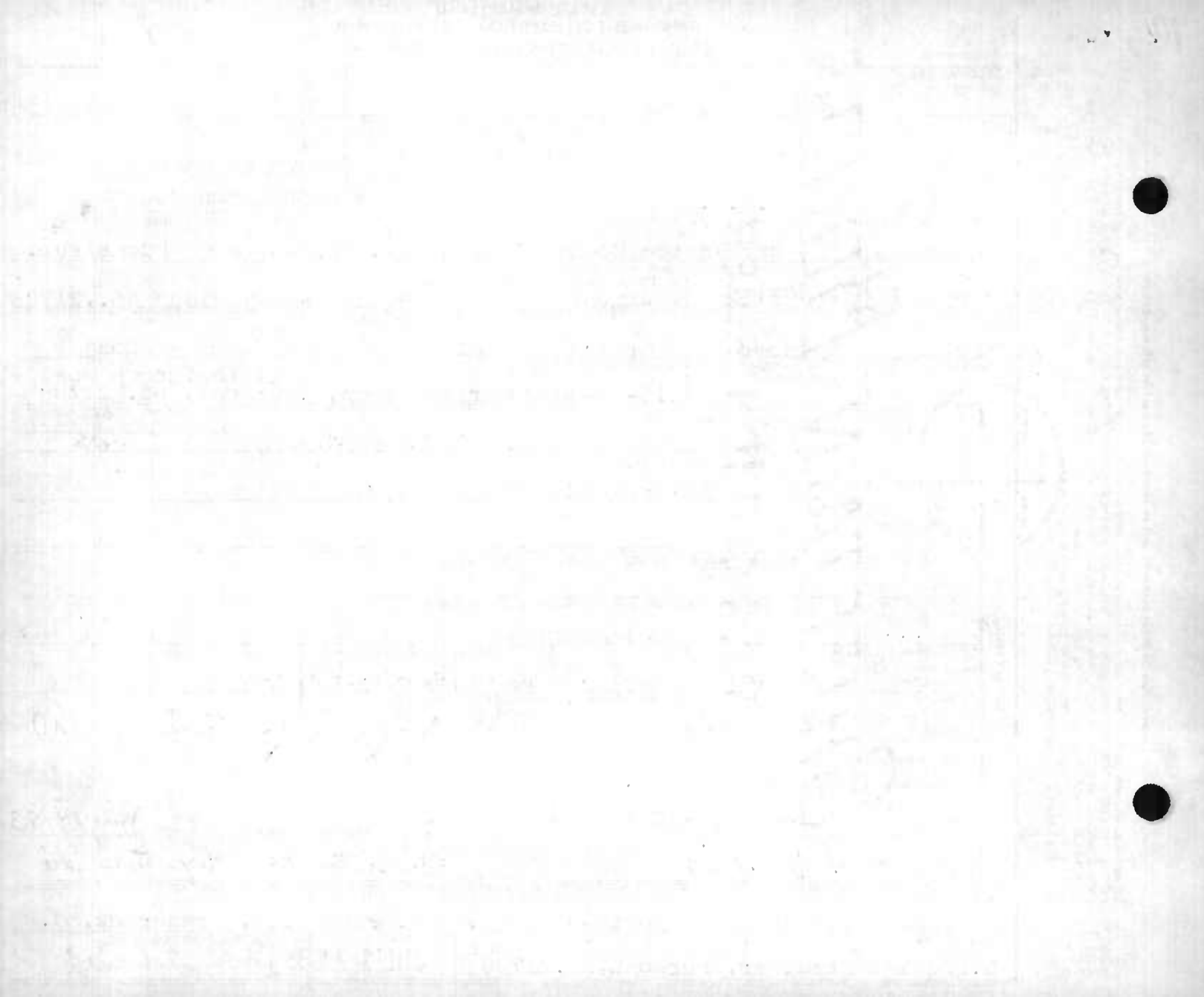


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WHILE THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR 115 ME (5))  
30M 7/73

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19874 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Randall Eugene Green										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 07 13 1983		2b. HOUR 2d. HOUR 9:54p					
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 3 1954		6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 07 13 1983		2d. HOUR 9:54p					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.							
7c. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Trauma Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construt.							
13a. STATE Maryland										13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8105 Rocky Ridge Rd., 21788	
14. FATHER'S NAME FIRST MIDDLE LAST Marlin Spencer Green					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gloria Ruth Long					17. INFORMANT ADDRESS 7421 Lewistown Road Marlin Green, Thurmont, Md. 21788							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-60-8652													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8122 IMMEDIATE CAUSE (a) multiple traumatic injuries (N869) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) with laceration of spleen (N865) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION 07-13-83				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? abdominal exploration						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 625 P.M. of July 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) motorcycle struck by car									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) RD				21f. LOCATION ST. RT. 194 & Dev. 11th St. Rd. 7421, Md.				CITY OR TOWN Frederick		COUNTY Frederick			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE H. N. Weeks				TITLE (SPECIFY) M.D. 2nd MEDICAL EXAMINER				DATE SIGNED July 14, 83									
EXAMINER'S NAME (TYPE OR PRINT) H. N. Weeks				ADDRESS 580 Northern Blvd Hagerstown, Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/16/83		23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gar.				23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.							
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer				104 East Main Street Thurmont, Md. 21788				25a. DATE REC'D. BY REGISTRAR JUL 19 1983				25b. REGISTRAR'S SIGNATURE John J. Canfield					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19875			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 7-9-83			
1. DECEASED NAME FIRST MIDDLE LAST Lottie May Grimm				2b. HOUR 4 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11-5-98		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS Route 2, Box 342 7782			
13a. STATE md.		13b. COUNTY Wash. Co.		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Ingram		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella ? Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 219-12-1690		17. INFORMANT ADDRESS Vernice Grimm - Sharpsburg, Md. 21782				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION	
4148		DUE TO, OR AS A CONSEQUENCE OF ASCUHD -				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO, OR AS A CONSEQUENCE OF				(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Gossweiler MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/9/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Gossweiler, M. D.				22e. ADDRESS Wash. Co. Hosp. - Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/12/83		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Samples Manor, Wash., Md.	
24. FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, W V 25425				25a. DATE REC'D. BY REGISTRAR JUL 25 1983		25b. REGISTRAR'S SIGNATURE John J. Canale	

Robert J. Gossamer, N. H.

1/15/87

1/15/87

George Henry Lee, N. H.

Wm. D. Hood, N. H.

Robert Gossamer, N. H.

Wm. D. Hood, N. H.

Wm. D. Hood, N. H.

George Henry Lee, N. H.

George Henry Lee, N. H.

George Henry Lee, N. H.

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George Henry Lee, N. H.

George Henry Lee, N. H.

George Henry Lee, N. H.

George Henry Lee, N. H.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										83-19876	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robin Lanette Hickey										2a. DATE KNOWN OF DEATH MONTH DAY YEAR xx 7 28 19 83	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-17-62		6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 28 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Finisher		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 26 Elizabeth Street 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Joseph Willis						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Lou Grimm					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-90-3793		17. INFORMANT ADDRESS Paul J. Willis Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cranio-cervical injuries</u> 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 PM 7-28-83 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto/auto collision					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Broadford&Rockdale Rds. Washington Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margareta A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 7-29-83			
EXAMINER'S NAME (TYPE OR PRINT) Margareta A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-1-83		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park Hagerstown Wash. Md.				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland				305 N. Potomac Street				25a. DATE REC'D. BY REGISTRAR AUG 8 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carney</i>	

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



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TO : DIRECTOR, FBI (100-441111)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]

RE: [Illegible]  
DATE: 1-10-64

100-441111-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19877			
1. FOR STATE REGISTRAR <b>Evelyn Lorraine Highbarger</b>							
1. DECEASED NAME (TYPE OR PRINT) <b>Hagbarger Evelyn</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 18, 1983</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 8, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Keedysville, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Interior</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Keedysville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George S. Line</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>C. Louise Gates</b>		16. ADDRESS <b>3 S. Main St.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-14-2565</b>		17. INFORMANT <b>Mr. Douglas E. Highbarger, Keedysville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> 4019 DUE TO, OR AS A CONSEQUENCE OF (b) <b>primary pulmonary hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>				22e. ADDRESS <b>125 HOWELL RD HAGERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7-19-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash. Co., Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>				25a. DATE REC'D. BY REGISTRAR <b>1111 22 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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1951  
 July 16, 1951  
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 Female  
 White  
 Nov. 8, 1920  
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 Washington  
 U. S. A.  
 Washington County Hospital  
 Secretary Dept. of Interior  
 Washington  
 Washington  
 Washington  
 George  
 8.  
 Fine  
 6.  
 Louise  
 3 S. Main St.  
 215-1-25-2  
 W. Douglas R. H. Douglas, Jr.  
 3 S. Main St.  
 Washington, D.C.

20  
 1951  
 1-18-51  
 Washington  
 John H. Seal, Jr.  
 3 S. Main St.  
 Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <u>Guy Alton Hoopengardner</u>		
2a. DATE OF DEATH MONTH DAY YEAR <u>7-26-83</u>			2b. HOUR <u>1820</u> M		
3. SEX <u>M</u>		4. RACE <u>CAUC</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>9-8-13</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7c. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.					
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON COUNTY HOSP.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>					
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hancock</u>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Rt.1</u> <u>21750</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>John F. Hoopengardner</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elsie G. Bottenfield</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>207 01 5635</u>		17. INFORMANT ADDRESS <u>Jane Hoopengardner Same as 13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1930</u> IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER, thyroid</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>LUNG METASTASIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u> <u>UNKNOWN</u> <u>UNKNOWN</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>a</u>					
19a. DATE OF OPERATION <u>6-28-83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>thyroid CANCER</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> 19 <u>83</u> , to <u>7-26</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>7-26</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edson Hawbaker M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>7-26-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>7-29-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Buck Valley Christian</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Warfordsburg, Fulton, Pa.</u>		23e. LOCATION CITY OR TOWN COUNTY STATE <u>17267</u>			
24. FUNERAL DIRECTOR NAME <u>Richard D. Grove</u>		ADDRESS <u>Hancock Md</u>		25. DATE RECD. BY REGISTRAR <u>AUG 8 1983</u>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19879

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert Louring HUFF, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 23, 1983</b>		2b. HOUR <b>M</b>					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 3, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>349 West Side Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>sub station foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>electricity</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>349 West Side Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louring F. Huff</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel E. Morningstar</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1948</b>		17. INFORMANT ADDRESS <b>Mrs. Rosemary D. Huff, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOGENIC CARCINOMA</b> (c) <b>WITH Multiple</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Edw. Hooster MD</b>			DEGREE			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edw. Hooster MD</b>			22e. ADDRESS <b>1825 Howell RD HAGERSTOWN, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 26, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Casper</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the study. It also mentions the scope of the study and the limitations of the study.

2. The second part of the report is a literature review. It discusses the work of other researchers in the field of the study. It mentions the methods used by other researchers and the results of their studies. It also discusses the strengths and weaknesses of the work of other researchers.

3. The third part of the report is a description of the methods used in the study. It discusses the data collection methods and the data analysis methods. It also discusses the validity and reliability of the methods used in the study.

4. The fourth part of the report is a presentation of the results of the study. It discusses the findings of the study and the conclusions drawn from the findings. It also discusses the implications of the findings for practice and for research.

5. The fifth part of the report is a discussion of the limitations of the study. It discusses the strengths and weaknesses of the study and the limitations of the study. It also discusses the implications of the limitations for practice and for research.

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1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the study. It also mentions the scope of the study and the limitations of the study.

2. The second part of the report is a literature review. It discusses the work of other researchers in the field of the study. It mentions the methods used by other researchers and the results of their studies. It also discusses the strengths and weaknesses of the work of other researchers.

3. The third part of the report is a description of the methods used in the study. It discusses the data collection methods and the data analysis methods. It also discusses the validity and reliability of the methods used in the study.

4. The fourth part of the report is a presentation of the results of the study. It discusses the findings of the study and the conclusions drawn from the findings. It also discusses the implications of the findings for practice and for research.

5. The fifth part of the report is a discussion of the limitations of the study. It discusses the strengths and weaknesses of the study and the limitations of the study. It also discusses the implications of the limitations for practice and for research.

A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19380

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE KATHERINE LAST RUIN			2a. DATE OF DEATH MONTH DAY YEAR 7 25 83		2b. HOUR 11 <sup>45</sup> PM
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11 12 1900	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clearspring, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (OF WORK OR USUAL OF WORKING LIFE) Aircraft	12b. KIND OF BUSINESS OR INDUSTRY Aircraft	
13a. STATE Md.			13b. COUNTY Washington	13c. CITY OR TOWN Clearspring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John P. Hose			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Forsythe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-8710	17. INFORMANT ADDRESS 366 Antietam Dr. Mildred Chambers Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of ascending colon with lines metast. b. metast. c. metast. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Jaundice, anemia.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	21g. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1900 to 1970 and that (I) (we) last saw the deceased on 22 July 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard T. Blair, M.D.		22c. DATE SIGNED 27 July 1983		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Blair + 88d	
22e. PHYSICIAN'S ADDRESS Hagerstown, Md.		22f. ADDRESS Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 28, 1983	23c. NAME OF CEMETERY OR CREMATORY Blair's Valley Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clearspring, Wash., Md.
24. FUNERAL DIRECTOR'S NAME Minnich Funeral Home, Hagerstown, Md.		24b. DATE REC'D. BY REGISTRAR AUG 01 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1880

e

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1. STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Celia Elaine Jacobs					2a. DATE OF DEATH MONTH DAY YEAR July 17, 1983			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 17, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
12. CITY OR TOWN OF DEATH Hagerstown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Home				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY Home		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Harr					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Anna McAllister					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Leon Gossard Hagerstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs Years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>70</u> , to <u>17 July</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11 July</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (did) (did not) view the body after death.)										
22b. SIGNATURE <u>Scutlison</u> <u>MD</u>					DEGREE			22c. DATE SIGNED <u>7/18/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J.D. Wilson, M.D.</u>					22e. ADDRESS <u>580 Northern Ave. Hagerstown, MD 21740</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>July 20, 83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown Wash. Md.</u>			
24. FUNERAL DIRECTOR <u>Thompson Funeral Home</u>					25a. DATE REC'D. BY REGISTRAR <u>JUL 22 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPH		MIDDLE	LAST KNOWSKI		2a. DATE OF DEATH		MONTH July	DAY 7	YEAR 1983	2b. HOUR 120 <sup>PM</sup>
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. US Navy		12b. KIND OF BUSINESS OR INDUSTRY Gov't				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY Wash		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Nursery Rd. 21740				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Knowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tilly Stevonsky								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Norma L. Knowski Same as #13						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

4860 IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

Respiratory Failure

(b) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Frederic H. Kross M.D.		DEGREE M.D.		22c. DATE SIGNED 7/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Frederic H. Kross M.D.		1825 Howell Rd., Hagerstown Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 7/15/83		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE San Diego San Diego Calif.	
24. FUNERAL DIRECTOR NAME ADDRESS Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR JUL 19 1983			
				25b. REGISTRAR'S SIGNATURE John J. [Signature]			

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

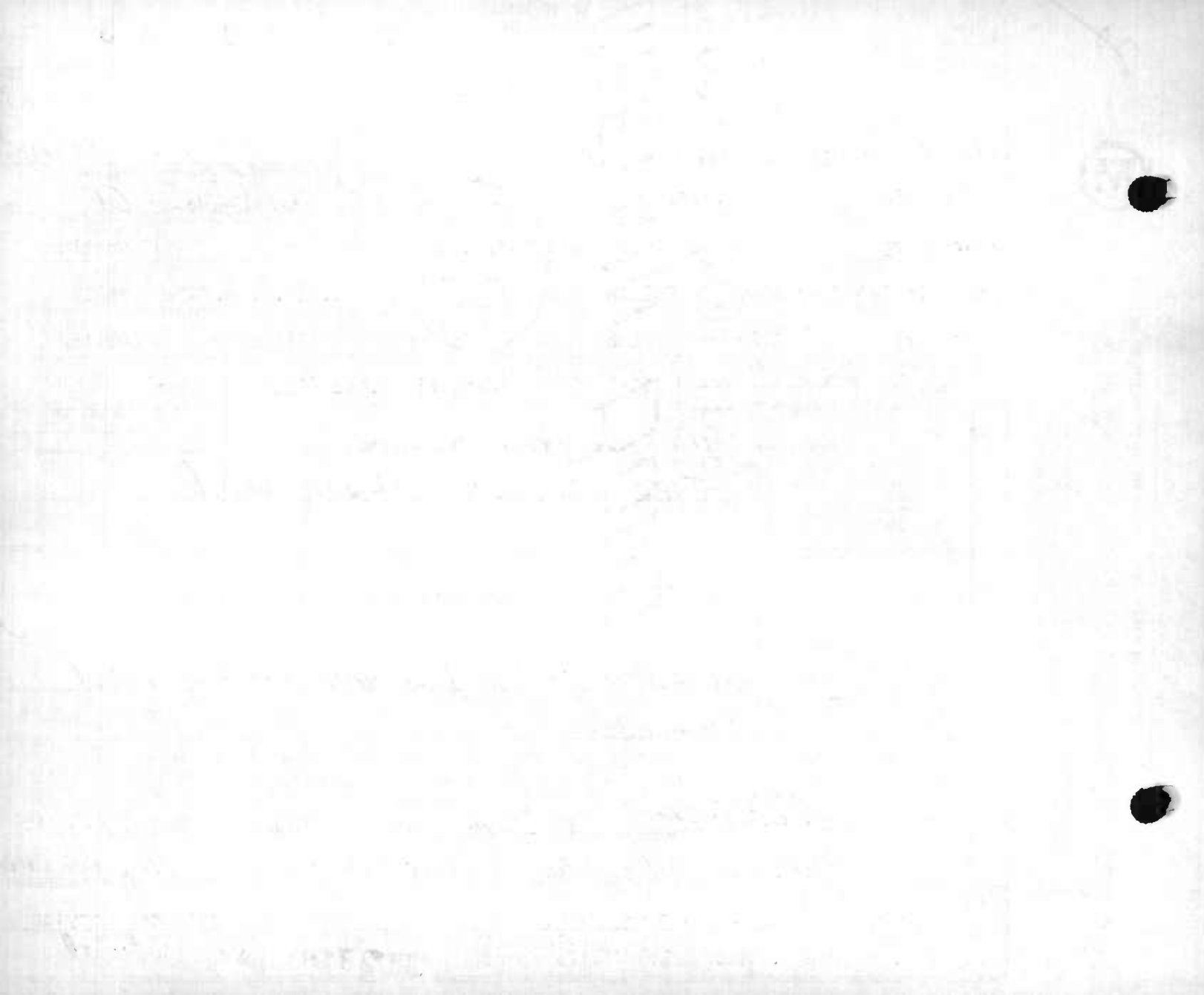
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

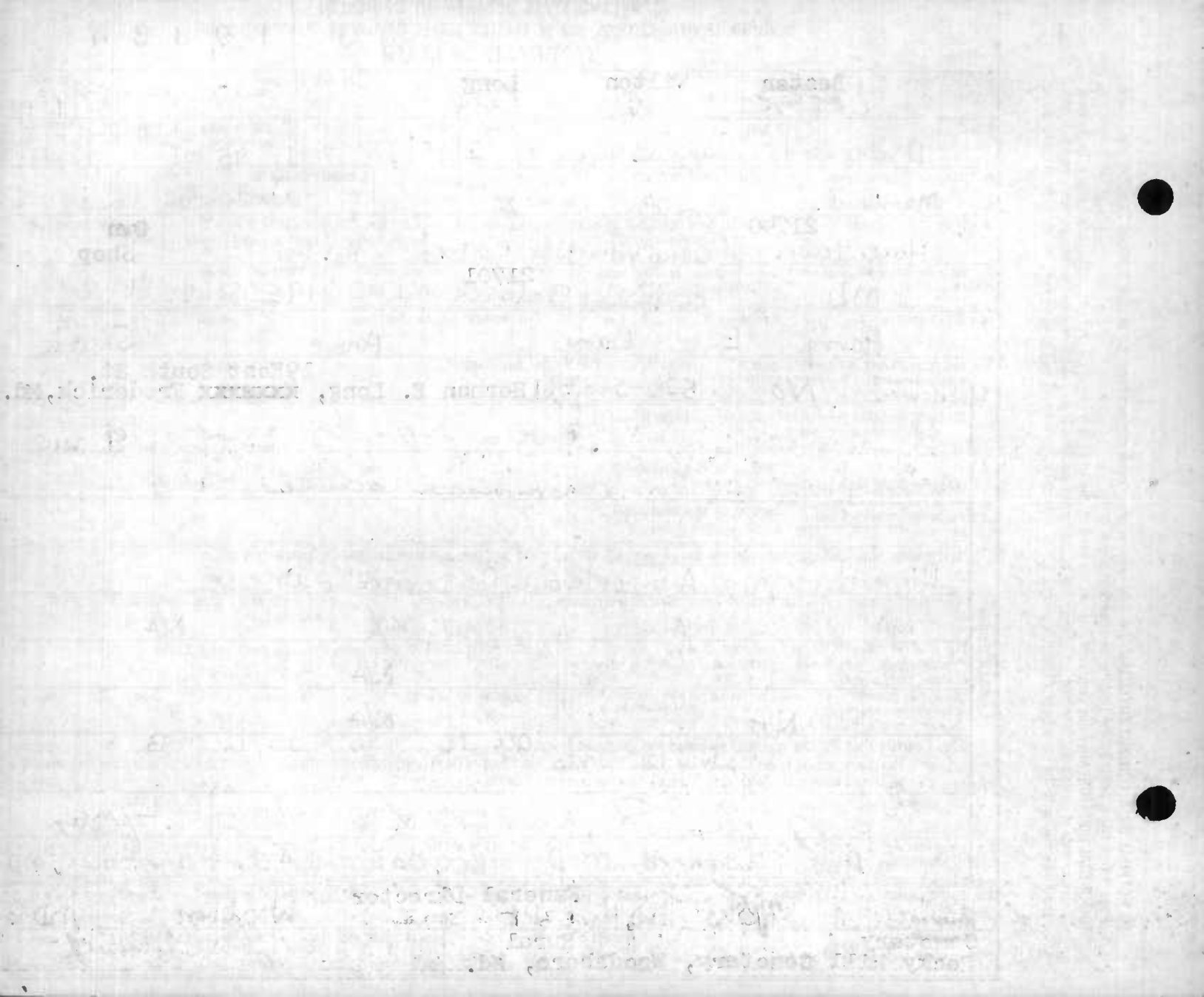
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19883	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>David Clay Lee</u>										2a. DATE KNOWN OF DEATH ESTIMATED <u>July 22 1983</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>July 26 1942</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>40</u> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD <u>July 22 1983</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington Ct.</u> MD.	
10. CITY OR TOWN OF DEATH <u>Sharpsburg</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Potomac River nr. Taylors Landing</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Teacher</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>West Virginia</u>				13b. COUNTY <u>Berkeley</u>		13c. CITY OR TOWN <u>Falling Waters</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Rt. 1 (P.O. Bx. #53) 25419</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Robert Clay Lee</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Esther Billmeyer Eutsler</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>no</u>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>213-40-6788</u>		17. INFORMANT ADDRESS <u>Katherine G. Lee (item 13 above)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Head Trauma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Tree limb falling striking head</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>5:00 P.M. July 22 1983</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Tree limb fell striking head</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Potomac River</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Allen W. Ditto</u>				TITLE (SPECIFY) M.D. <u>Asst. Dir.</u> MEDICAL EXAMINER				DATE SIGNED <u>7/22/83</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Allen W. Ditto M.D.</u>				ADDRESS <u>1610 Oak Hill Ave Hyattsville</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>July 25, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Sharpsburg Washington Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Major M. Osborne</u>				ADDRESS <u>P.O. Box # 348 Williamsport,</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 28 1983</u>		25b. REGISTRAR'S SIGNATURE <u>Sam J. Canfield</u>	



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68





2

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19885

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR

Thessalonian Marshall 7 15 83 5:30 P M

3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS

m BLACK 2 7 06 77 YRS. MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH MD.

10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

Hagerstown Washington Co. Hospital Retired

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS

md Wash. Hagerstown YES 187 Berkson Ave. 21740

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

ARTHUR WMN MARSHALL UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

yes ARMY 237-05-6018 Rose A. Duckett 4826 FORT-TOTTEN DRIVE WASHINGTON, DC 20011

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4140 Cardiovascular arrest Immediate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASH (c) Hypertension year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) (b) (c)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 22b. SIGNATURE DEGREE 22c. DATE SIGNED

Massoud B. Alizadeh MD 7/16/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS

MASSOUD B. ALIZADEH 363 S. Cleveland Ave Hagerstown Md 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE

BURIAL 7/20/83 Rose Hill Cem. Hagerstown Wash. Md.

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Dennis L. Davis Smithsburg, Md. 21783 JUL 25 1988

For the purpose of this report, the term "agricultural production" is defined as the total quantity of agricultural products produced in the United States during the year.

The following table shows the total quantity of agricultural products produced in the United States during the year 1948, expressed in millions of bushels.

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

For the purpose of this report, the term "agricultural production" is defined as the total quantity of agricultural products produced in the United States during the year.

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The following table shows the total quantity of agricultural products produced in the United States during the year 1948, expressed in millions of bushels.

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										19886			
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Charles Fred Martin					2a. DATE OF DEATH MONTH DAY YEAR July 28, 1983				2b. HOUR 2:00 AM				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 S. Walnut St. Apt. 201 B				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) plant superintendent			12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 11 S. Walnut St. Apt. 201 B	
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Martin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Zeigler								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 214-09-8526		17. INFORMANT ADDRESS LOuise Martin 11 S. Walnut St. Apt. 201 B						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WIDE SPREAD METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of right lung</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>MONTHS</u> <u>months</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>61</u> , to <u>July 28</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>July 28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Harold Trinch MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/28/83</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H.R. Trinch</u>				22e. ADDRESS <u>Hagerstown, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sharpsburg Washington Md.					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR AUG 02 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					
415 E. Wilson Blvd. Hagerstown, Md. 21740													



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MINOR & MAJOR HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19887

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Rose LAST McBride			2a. DATE OF DEATH MONTH DAY YEAR 7 24 83			2b. HOUR 2:32 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 24, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? Washington County		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Medical	
13a. STATE Md.				13b. COUNTY Wash. County		13c. CITY OR TOWN Williamsport	
14. FATHER'S NAME FIRST Charles MIDDLE Francis LAST Fleckenstein				15. MOTHER'S MAIDEN NAME FIRST Mae MIDDLE Elizabeth LAST Morrison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-32-2937		17. INFORMANT ADDRESS Francis L. McBride (item 13 above)			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1749

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

pathological fracture of left femur

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

heme

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. H. Scouter				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-24-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SECONDARI				22e. ADDRESS BOONSBORO 21713			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jul. 25, 1983		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington Maryland	
24. FUNERAL DIRECTOR NAME Major M. Osborne				ADDRESS Wmspt, MD 21795		25a. DATE REC'D. BY REGISTRAR JUL 28 1983	
						25b. REGISTRAR'S SIGNATURE B. J. Carver	

BP

ANALYSIS OF VARIANCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				1988			
1. FOR STATE REGISTRAR <i>John F</i>				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>John F McIntire, Sr.</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>7 2 83</i> 2b. HOUR <i>3:28</i> M			
3. SEX <i>m</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 6 01</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hospital</i>		12a. USUAL OCCUPATION (TYPE, TRADE, BUSINESS, OR INDUSTRY) <i>Truck Driver</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Oil Co.</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Wash.</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles McIntire</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nettie Sanders</i>		13e. STREET ADDRESS <i>Rt 88, Box 35 Avalon Manor</i> 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>214-09-0177</i>		17. INFORMANT ADDRESS <i>Mr. John F. McIntire, Jr., Hagerstown, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: <i>4860</i> IMMEDIATE CAUSE (a) <i>Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.W. Lesh MD</i> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>7-2-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William W. Lesh, M.D.</i>				22e. ADDRESS <i>411 Division Avenue Hagerstown, Maryland 21740</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>July 5, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>	
24. FUNERAL DIRECTOR <i>MINNICH FUNERAL HOME</i> ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Maryland 21740</i>				25a. DATE REC'D. BY REGISTRAR (I) REGISTRAR'S SIGNATURE <i>John J. Lesh</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19889

FOR  
1 - STATE  
REGISTRAR

REG. NO.

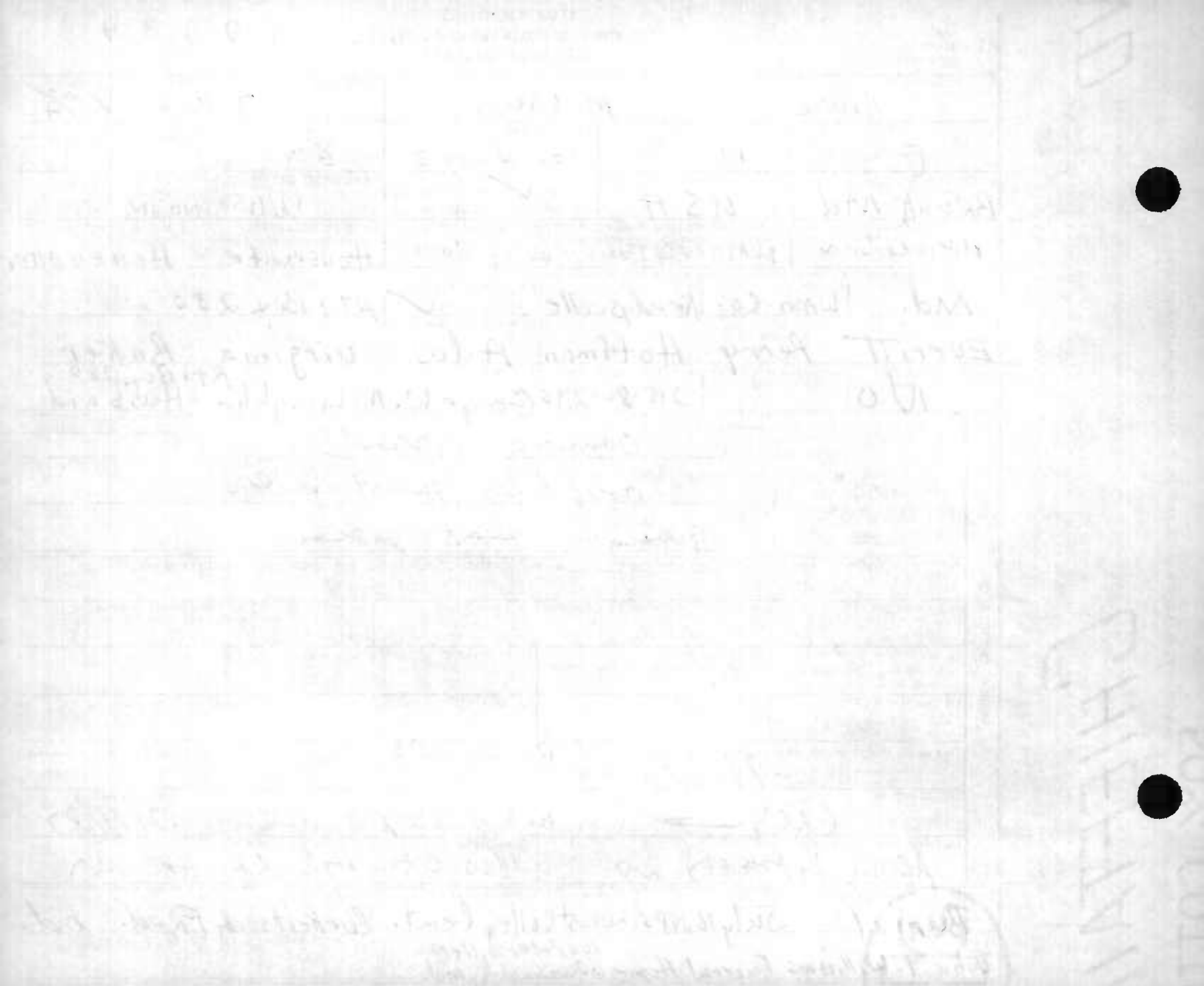
1. DECEASED NAME (TYPE OR PRINT) <b>ANNIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-14-83</b>			2b. HOUR <b>6:08 A</b> M				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-2-1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BRUNT. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON Co. MD.</b>				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON County Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Wash. Co.</b>		13c. CITY OR TOWN <b>Keedysville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 280 21752</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Everitt Perry Hoffman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Virginia Baker</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-80-2199</b>			17. INFORMANT <b>George W. McLaughlin - Husband</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>heart disease</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/7/83</b> to <b>7/14/83</b> , that (I) (we) lost saw the deceased alive on <b>7/13/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>ABDUL LATHEED MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/14/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL LATHEED MD</b>			22e. ADDRESS <b>1800 Oak Hill Dr Hager, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 16, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locust Valley Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Buckeitsville Fred. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John T. Williams</b>			ADDRESS <b>400 Petersville Rd. Brownsburg, Md.</b>			25. DATE REC'D BY REGISTRAR <b>JUL 25 1983</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19890			
1. DECEASED NAME (TYPE OR PRINT) <b>Harvey Denton MEHAFFEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 3, 1983</b>			
3. SEX <b>male</b>				4. RACE <b>white</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 20, 1900</b>				6. AGE (IN YEARS (LAST BIRTHDAY)) <b>82</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garlock Memorial Home</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Coal Co.</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Wash.</b>			
13c. CITY OR TOWN <b>Smithsburg</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>3 E. Water St. 21783</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward MehaFFEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella May Greenawalt</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>220-10-7505</b>			
17. INFORMANT ADDRESS <b>Mrs. Marian L. Swisher / Smithsburg, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Death by gunshot wound of the chest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Defensive gunshot wound of the chest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart Disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8-7 60 5-56 85</b>			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>60 5-56 85</b>			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>5-56 85</b> to <b>5-56 85</b> , that (I) (we) last saw the deceased alive on <b>5-56 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) <b>view the body after death.</b>							
22b. SIGNATURE <b>W. W. W. W.</b>				22c. DATE SIGNED <b>7-5-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. R. Landis</b>				22e. ADDRESS <b>582 John W. Cleveland, Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 6, 1983</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Quincy, Franklin, Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>Lavis Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <b>JUL 6 1983</b>			





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MAXWELL WARHAM MILLER</b> <i>MAXWELL W MILLER</i>		2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 17, 1983</b>		2b. HOUR <b>12:13AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 6, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>WASH.</b>	13c. CITY OR TOWN <b>HAGERSTOWN</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>21740 1027 Marshall St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD MILLER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY "STRALEY"</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-09-7551</b>		17. INFORMANT ADDRESS <b>IRENE MILLER same as 13 e</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arrest</b> 4/00 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Inf.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)				
MEDICAL CERTIFICATION				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>R. H. J. Doser</i>		DEGREE <b>MD</b>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/20/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park Hagerstown, Wash. Md.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Md.</b>		24. FUNERAL DIRECTOR'S NAME <b>Rest Haven Funeral Chapel, Inc</b> <b>1601 Pennsylvania Ave. Hagerstown, Md.</b>		
25a. DATE REC'D. BY REGISTRAR <b>JUL 26 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Gried</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





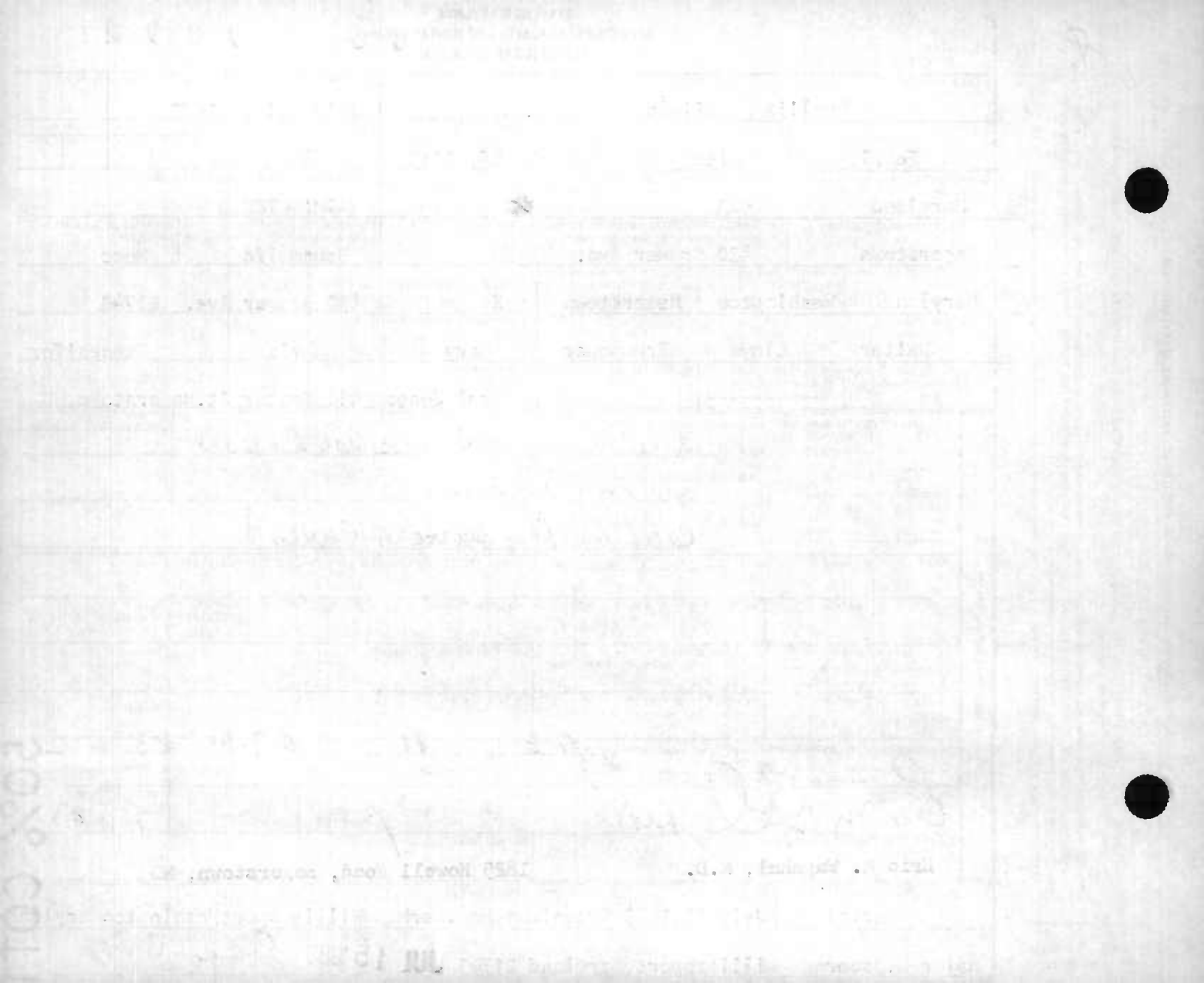
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				19892			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Phyllis Eileen MILLER				2a. DATE OF DEATH MONTH DAY YEAR July 10, 1983			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 28, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 430 Brewer Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. STREET ADDRESS 430 Brewer Ave. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Lloyd Trumpower				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Avis Stonesifer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Carol Jones 411 Center St. Hagerstown, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardio-Respiratory Arrest</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from <u>4-8</u> 19 <u>81</u> , to <u>7-10</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>6-29</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <u>Eric M. Wagshal, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-11-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal, M.D.				22e. ADDRESS 1825 Howell Road, Hagerstown, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 13, 1983		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington Maryland	
24. FUNERAL DIRECTOR NAME Major M. Osborne				25a. DATE REC'D. BY REGISTRAR JUL 15 1983			
ADDRESS Williamsport, Maryland 21795				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19893

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Theodore R Minter			2a. DATE OF DEATH MONTH DAY YEAR 7 - 15 - 83			2b. HOUR 4:50 P.M.	
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 2 9 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASH. CO. MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE OHIO		13b. COUNTY		13c. CITY OR TOWN Cleveland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 4438 E 141 St.		99999					
14. FATHER'S NAME FIRST MIDDLE LAST Bailey Minter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Minter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 285-05-1742		17. INFORMANT ADDRESS Apt. 910 PKWY Anneta Merryweather 1190 W. Northern			

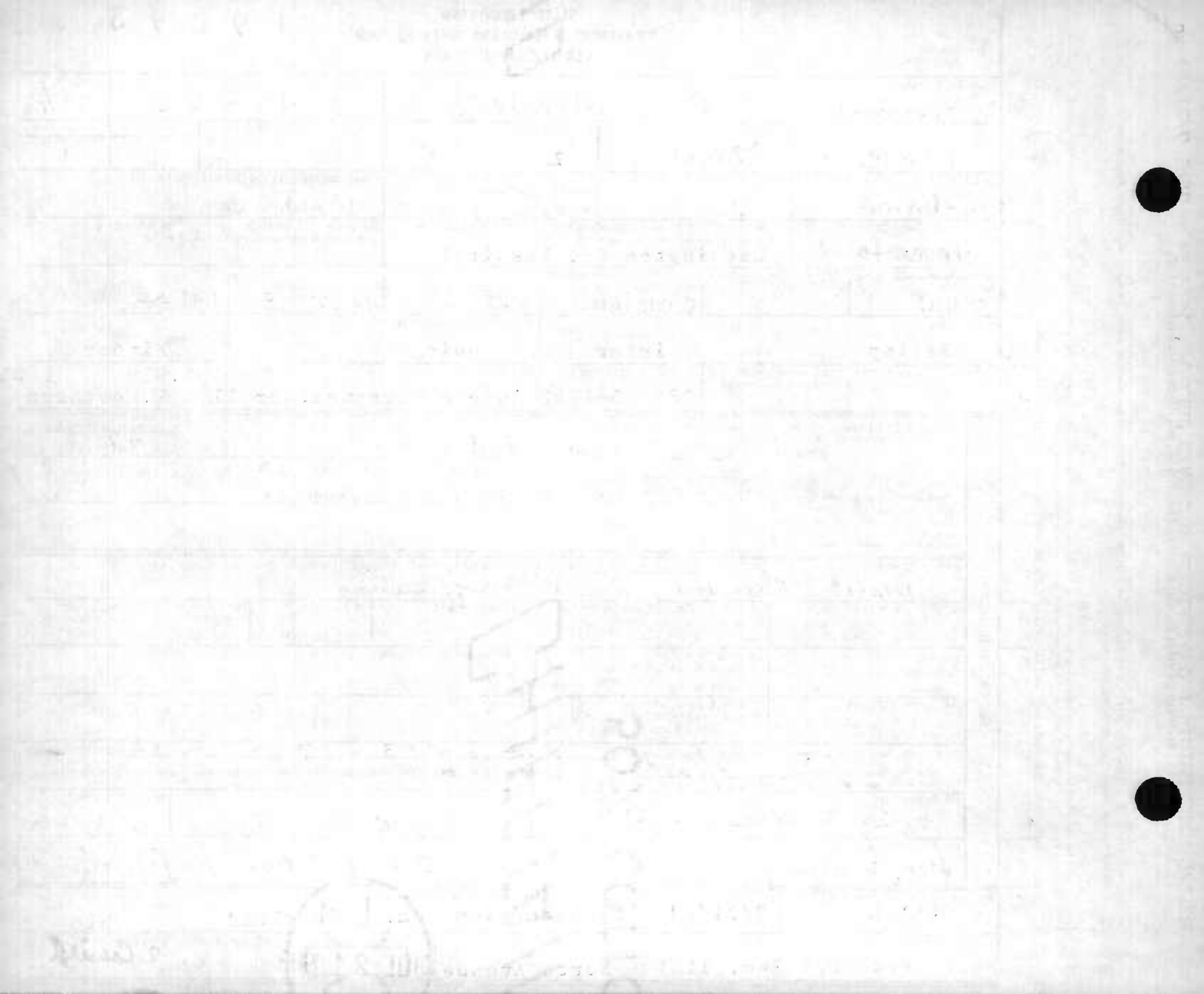
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction with Congestive Heart Failure (b) Atherosclerotic Vascular Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  
Diabetes Mellitus, Renal Insufficiency

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/12, 19 83, to 7/15, 19 83, that (I) (we) last saw the deceased alive on 7/13/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mary E. Money, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary E. Money, M.D.				22e. ADDRESS 1708 Oak Hill Ave, Hagerstown, Md. 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/21/83		23c. NAME OF CEMETERY OR CREMATORY Highlandview Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cleveland Ohio	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JUL 21 1983		25b. REGISTRAR'S SIGNATURE J. Church	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with a 72-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

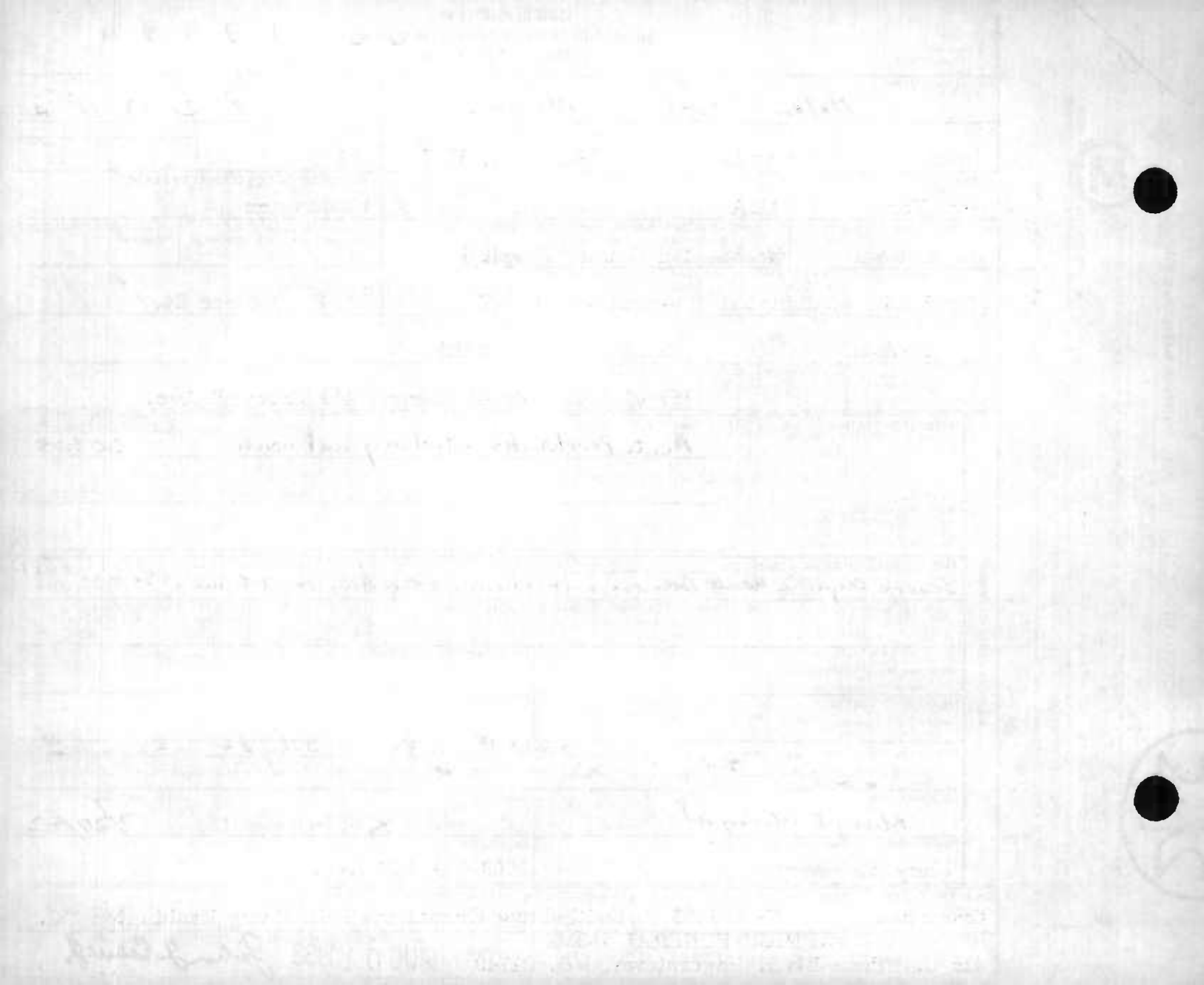
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19894

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen Agnes Morgan</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>7 29 83</i>		2b. HOUR <i>12<sup>35</sup> AM</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 24, 1909</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. CITY OR TOWN OF DEATH <i>Hagerstown</i>		9b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>	
13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>322 S. Potomac St.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Tarence Condon</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edith</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>157-01-1008</i>		17. INFORMANT <i>Frank Morgan</i>		ADDRESS <i>440 McDowell Ave.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Peritonitis, etiology unknown</i> <i>5679</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>60 hrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Severe Organic Heart Disease with Chronic Congestive Heart Failure, Severe COPD</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED <i>7/29/83</i>		22b. ADDRESS <i>1708 Oak Hill Ave.</i>	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary E. Money, MD</i>		22e. ADDRESS <i>1708 Oak Hill Ave.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>7-30-1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Smithsburg Crematory</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Smithsburg Washington Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd. Hagerstown, Md. 21740</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 01 1983</i>	
25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) PATRICIA L. MOWRY			2a. DATE OF DEATH MONTH DAY YEAR July 29 1983		2b. HOUR 12:10 a.m.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 23 1939	6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTERN MARYLAND CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Adamstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. # 1, Box 37 B 21710		
14. FATHER'S NAME FIRST MIDDLE LAST Edmond H. Rhodes, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Louise Jordan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-3879		17. INFORMANT ADDRESS Edmond H. Rhodes, Jr. 28235 Kemptown Rd. Damascus, Md. 20872		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4-300 IMMEDIATE CAUSE (a) Bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) subarachnoid hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ruptured aneurysm of anterior communicating artery						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 1976 1976
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) (this hospital) attended the deceased from 2-2-77, 19, to 7-29-83, 19, that (I) (XX) lost saw the deceased alive on 7-29-83, 19, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XX) (did) (XXX) view the body after death.						
22b. SIGNATURE Fe U. Porciuncula, M.D.				22c. DATE SIGNED 7-29-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M.D.				22e. ADDRESS WESTERN MARYLAND CENTER, HAGERSTOWN, MARYLAND 21740		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 1, 1983		23c. NAME OF CEMETERY OR CREMATORY St. Michael's		23d. LOCATION CITY OR TOWN COUNTY STATE Poplar Springs, Howard, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR AUG 04 1983		25b. REGISTRAR'S SIGNATURE John J. Connel

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				19896			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) May Olivia Newcomer				2a. DATE OF DEATH MONTH DAY YEAR 7-19-83		2b. HOUR 7:34 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 24 1888		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Smithsburg, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney Keedy Home-Boonsboro Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Bank	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Wash.		13c. CITY OR TOWN Boonsboro	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel H. Newcomer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Susan Beard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-42-7728		17. INFORMANT ADDRESS Mr. Richard K. Newcomer, Smithsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic Heart Dh DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE ASB				DEGREE MD		22c. DATE SIGNED 7/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL LATHEED MD				22e. ADDRESS 1600 Oak Hill Rd. Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 19, 1983		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash., Md.	
24. FUNERAL DIRECTOR Davis Funeral Home, Smithsburg, Md., 21783				25a. DATE REC'D. BY REGISTRAR JUL 27 1983		25b. REGISTRAR'S SIGNATURE John J. Linnick	

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19897

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE Leona NEWKIRK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 24 83</b>		2b. HOUR <b>11:21 A</b>
3. SEX <b>FEMALE</b>	4. RACE <b>C</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 12 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> RS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Funkstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>8 E. Cemetery St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel R. Grove</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia ?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Mr. Millard L. Martin Hag. Md.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Myocardial Infarct**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**Minutes**

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Generalized Atherosclerosis****yrs**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

**None**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

**-----**

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. **None** 19 **79**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

**-----**

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
**None**

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE  
**-----**

22a. I certify that (I) (his) hospital attended the deceased from **July**, 19 **79**, to **May**, 19 **82**, that (I) (we) lost  
saw the deceased alive on **May 28**, 19 **82**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

**W W Lesh M.D.**

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

**7-25-83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**William W. Lesh M.D.**

22e. ADDRESS

**411 Division Ave Hagerstown, Md 21740**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)**Burial**

23b. DATE

**July 26, 83**

23c. NAME OF CEMETERY OR CREMATORY

**Rose Hill**

23d. LOCATION

**Clearspring Wash. Md.**

24. FUNERAL DIRECTOR

**Thompson Funeral Home Clearspring Md.**

25a. DATE REC'D. BY REGISTRAR

**JUL 29 1983**

25b. REGISTRAR'S SIGNATURE

**John J. Lesh**

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : SAC, NEW YORK  
FROM : SAC, NEWARK  
SUBJECT: [Illegible]  
RE: [Illegible]

[Illegible text block]

[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19898

1. DECEASED NAME (TYPE OR PRINT) <b>GRACE NICKERSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-13-83</b>		2b. HOUR <b>2:20 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Blk</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 7 04</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.		
10. CITY OR TOWN OF DEATH <b>EASTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>	13b. COUNTY <b>PA</b>	13c. CITY OR TOWN <b>Brownsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>P.O. Box 288</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Crisby</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary C Robinson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-01-6324</b>		17. INFORMANT <b>Mary F Anderson</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>WKS</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/2 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/12/83</b> , 19 <b>83</b> , to <b>7/13</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>7/12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Donald Lewers M.D.</b>				22c. DATE SIGNED <b>7/13/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald Lewers, M.D.</b>				22e. ADDRESS <b>Easton, Md. 21601</b>	
23a. BURIAL, CREMATION, REMOVAL (REFERENCE)		23b. DATE <b>7/18/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesler Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chesler Ex MD</b>
24. FUNERAL DIRECTOR NAME <b>George Deohill</b>		ADDRESS <b>Easton Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John P. Conner</b>

MEDICAL CERTIFICATION



CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19899			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST <b>PAUL PRESTON PEARCE</b>				July 31, 1983 M			
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 30, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>80</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colton Villa Nursing Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13e STREET ADDRESS <b>608 Highland Way 21740</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Milburn Pearce</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unezar Laro Williams</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>705-10-7655</b>		17 INFORMANT ADDRESS <b>Kathryn L. Downin, Hagerstown, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 5319 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastric ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. Waheed</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Abdul Waheed, M.D.</b>				22e ADDRESS <b>1600 Oak Hill Ave, Hagerstown, MD</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 4, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Princeton, West Virginia</b>	
24 FUNERAL DIRECTOR'S NAME <b>MINNICH FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Joe J. Connel</b>	
415 E. Wilson Blvd., Hagerstown, Md. 21740							



20% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19900

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Maude Catherine POFFENBERGER		July 16, 1983		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female	White	MONTH DAY YEAR September 17, 1898	84 YRS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U S A		WASHINGTON MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Colton Villa Nursing Center		Housewife		Home
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Sharpsburg	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt. 1 21782	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Charles (nmi) Irvin		Mary Ellen Poffenberger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		214-36-0363		MD. 21701 Golda E. Culler 1212 Beechwood Dr. Frederick,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Abdul Wahed, MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ABDUL WAHEED, MD		1600 Oak Hill Ave Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		July 20, 1983	Mt. View Cemetery		Sharpsburg Washington Maryland
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Major M. Osborne		P.O. Box # 348 Williamsport, MD		25b. REGISTRAR'S SIGNATURE JUL 22 1983	

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RECEIVED  
JAN 10 1910

TO THE  
HONORABLE  
SPEAKER OF THE HOUSE OF REPRESENTATIVES  
WASHINGTON, D. C.

DEAR MR. SPEAKER:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the proposed amendment to the Constitution of the United States, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. H. [Signature]

Very truly yours,  
J. H. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph K. Price</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7 8 83</b>		2b. HOUR MN <b>12 MN</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 25 12</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>71</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Army Depot</b>			
13a. STATE <b>Penna.</b>		13b. COUNTY <b>Huntingdon</b>		13c. CITY OR TOWN <b>Shade Gap</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route # 1 17255</b>		99999	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel H. Price</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Belle Snyder</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		(IF YES, GIVE WAR OR DATES) <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>211-07-5553</b>		17. INFORMANT ADDRESS <b>Richard E. Price, Shade Gap, PA 17255</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lung Cancer with Metastasis to Bone</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Pneumonia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>06-30</b> , 19 <b>83</b> , to <b>07-08</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>07-08</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>ELI ROZA</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-8-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELI ROZA</b>						22e. ADDRESS <b>Washington County Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>7-12-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fair Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RD Shade Gap PA</b>				
24. FUNERAL DIRECTOR NAME <b>Maetin R. Bacon</b>						ADDRESS <b>Orbisonia, PA 17243</b>		25. DATE OF BURIAL <b>JUL 21 1983</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in truth and accuracy, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				19902			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>George H Ptacek</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>07 31 83</b>			
3. SEX <b>M</b>				2b. HOUR <b>1:23 PM</b>			
4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 12 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>59</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Seat Pleasant, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Negative Engraver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Defense</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Zedneck Ptacek</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amada Braun</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W. W. Two 578-22-6747</b>		17. INFORMANT ADDRESS <b>Mrs. Nota J. Ptacek, Rfd. 3 Box 573 Boonsboro, Md. 21713</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA of the lung</b> (c) <b>CENESTHIC MEMBRANES</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) did not view the body after death.							
22b. SIGNATURE <b>Wooden Mrs</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/1/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wooden</b>				22e. ADDRESS <b>1825 Howell RD HAGERSTOWN MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-3-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Bast, Jr. Boonsboro, Maryland 21713</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 3 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

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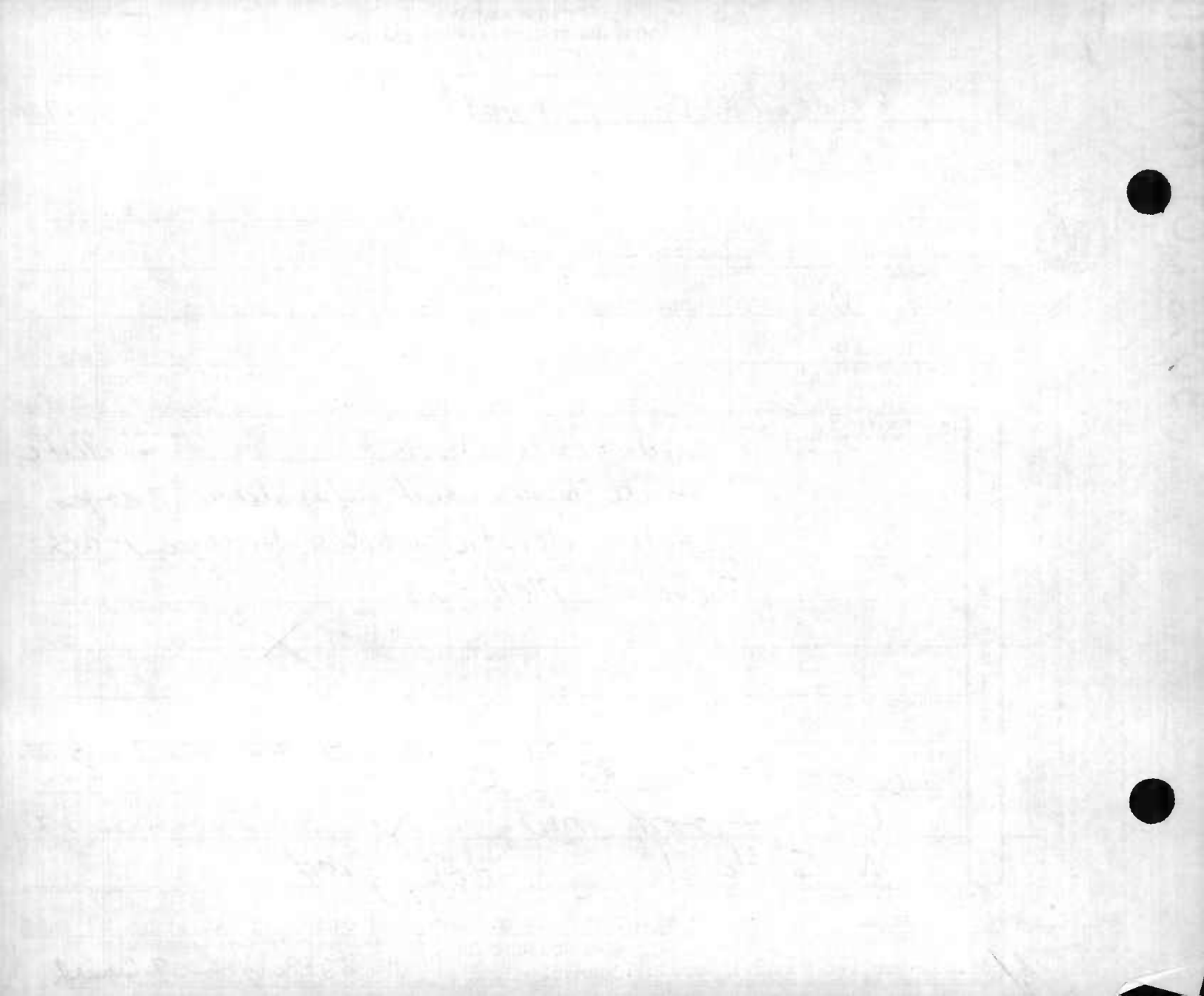


DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) <b>Frederick D. Purnell</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7-26-83</b>					2b. HOUR <b>2:27 AM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 30 1910</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>72 YRS.</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington MD.</b>				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>ALLEGANY</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. #3 Bedford Rd 21502</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Purnell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amanda Hartley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>214-07-1958</b>		17. INFORMANT ADDRESS <b>Mrs. Nancy Growden Rt. #3 Bedford Rd Cumberland, Md 21502</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> 4100										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b>										3 days		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease</b>										years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>7-21</b> , 19 <b>83</b> , to <b>7-26</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>7-26</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.												
22b. SIGNATURE <b>W S Hood MD</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>7-26-83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W S Hood</b>					22e. ADDRESS <b>HAG. md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 28/83</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Centenary U. Meth Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Silcox-Merritt Funeral Service, Cumberland, Md</b>					404 Decatur St					25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1983</b>		
										25b. REGISTRAR'S SIGNATURE <b>Joan J. Connel</b>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Gladys		MIDDLE Irene		LAST REEL		2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> July 26 1983		2c. DATE PRONOUNCED DEAD July 28 1983		2d. HOUR 11:45 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2e. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> July 26 1983		2f. HOUR 11:38 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mt. Briar, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington							
10. CITY OR TOWN OF DEATH Keedysville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rfd. 1 Box 107		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Keedysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 1 Box 108		21756			
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Abbott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Norris		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-8058		17. INFORMANT ADDRESS Rfd. 1 Box 107 Mrs. Gynolyn Castle, Keedysville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Edward W. Dittus		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED July 28, 1983							
EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dittus III		ADDRESS 217 W. Wash. St. - Hagerstown, Md 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-29-83		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION CITY OR TOWN Sharpsburg, Wash. Co., Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR John H. Bast, Jr.		ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR AUG 01 1983		REGISTRAR'S SIGNATURE John J. Conner							

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

NAME	ADDRESS	CITY	STATE	DATE
Mr. E. A. Tamm	U. S. Supreme Court Building	Washington	D. C.	June 11, 1952
Mr. J. Edgar Hoover	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Clegg	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Glavin	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Ladd	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Nichols	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Rosen	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Tracy	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Harbo	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Mohr	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Winterrowd	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Tele. Room	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Mr. Holloman	U. S. Department of Justice	Washington	D. C.	June 11, 1952
Miss Gandy	U. S. Department of Justice	Washington	D. C.	June 11, 1952

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,  
John H. Egan, Jr., Baltimore, Md. 21213

7-29-52  
Honorable Vice Consular  
Baltimore

AUG 1 1952  
J. Edgar Hoover



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										19905	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE I REPP</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 26, 1983</b>				2b. HOUR <b>9:58</b> AM		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 24, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS		8. IF SPENT 24 HRS. HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTERN MARYLAND CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Clearspring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RFD-2 Box 209 21722</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Yeakle</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jula Clopper</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-24-8864</b>		17. INFORMANT ADDRESS <b>Mr. Charles U. Repp RFD-2 CS</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>POSSIBLE ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Geno.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 29, 1983</b> , to <b>July 26, 1983</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>July 26, 1983</b> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <b>F. U. Porciuncula</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>7/26/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F. U. Porciuncula</b>				22e. ADDRESS <b>1500 PENNSYLVANIA AVE HAGERSTOWN, MARYLAND 21740</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 30, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blairs Valley</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clearspring Wash. MD.</b>			
24. FUNERAL DIRECTOR <b>Donald E. Thompson</b> Thompson Funeral Home Clearspring Md.						25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1983</b>					
25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>											

MEDICAL CERTIFICATION





Honorable Mr. Justice

Box 100

Winnipeg

Manitoba

Canada

18-84-34000, Charles D. Hogg, Esq.

Only 20, 18-84-34000, Charles D. Hogg, Esq.

18-84-34000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				1 9 9 0 6	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) STELLA PEARL RICE			2a. DATE OF DEATH MONTH DAY YEAR 7/14/83		2b. HOUR 6:15A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7/25/1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON CO.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COFFMAN HOME FOR AGED		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND	13b. COUNTY WASH.	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 217 Alexander St. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH RICE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA VIRGINIA ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ----		16b. SOCIAL SECURITY NO. 213-18-8242A		17. INFORMANT Hagerstown, Md. 21740 Mrs. Eva Hoffman/9 Dunn Irvin Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Thrombosis &amp; Hypertension</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12 July 1983</u> to <u>14 July 1983</u> , that (I) (we) last saw the deceased alive on <u>12 July 1983</u> , and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>J. D. Wilson, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 7/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.D. Wilson, M.D.		22e. ADDRESS 580 Northern Ave. Hagerstown, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/15/83	23c. NAME OF CEMETERY OR CREMATORY Broadfording Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Co. Md.	
24. FUNERAL DIRECTOR NAME 1601 Pennsylvania Ave. Hag. Md. Rest Haven Funeral Chapel, Inc.		25a. DATE REC'D. BY REGISTRAR JUL 19 1983 REGISTRAR'S SIGNATURE <u>John J. Carroll</u>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19907

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Vada</i> <i>Vada</i> <i>Ella</i> <i>Ridenour</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>7-13-83</i>		2b. HOUR <i>8:06</i> AM	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 11 04</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Md.</i>		13c. CITY OR TOWN <i>Smithsburg</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frisby - Moats</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha - Eaton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-30-9519</i>		17. INFORMANT ADDRESS <i>Mr. Wilbur L. Ridenour, Smithsburg, Md.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardiac Arrest*  
*2500*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *Diabetes Mellitus*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Arteriosclerotic Cardiovascular Disease*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*1 Hr.**8 yrs.**10 yrs.*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7-13</i> <i>83</i> , to <i>7-13</i> <i>83</i> , that (I) (we) lost saw the deceased alive on <i>7-13</i> <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did/did not view the body after death.							
22b. SIGNATURE <i>Charles F. Hess M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>7-13-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles F. Hess M.D.</i>				22e. ADDRESS <i>Smithsburg Md. 21783</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>July 15, 83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Davis Funeral Home, Smithsburg, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 18 1983</i>			
				25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

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2102-2103-000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19908			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 7-6-83			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grover Nathan Rudolph				2b. HOUR 2:25 PM			
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR January 11, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer & mechanic		12b. KIND OF BUSINESS OR INDUSTRY self-emp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Wade Rudolph				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Heishman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-09-6408		17. INFORMANT ADDRESS Annie Rudolph, Hagerstown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma of the Right Lung - widespread metastases							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b) Right Lung - widespread metastases							
DUE TO, OR AS A CONSEQUENCE OF (c) metastases							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/28/83 to 7/6/83, that (I) (we) lost saw the deceased alive on 7/5/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Brull				DEGREE MD		22c. DATE SIGNED 7/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull				22e. ADDRESS 1459 Potomac Ave.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25. DATE REC'D. BY REGISTRAR JUL 12 1983 REGISTRAR'S SIGNATURE John J. Gassner			

BP



Handwritten text at the bottom left, possibly a date or signature, appearing as 'JUL 1 1901'.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19909

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Fred Lloyd Rudy</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 3 83</b>		2b. HOUR <b>9:55 AM</b>
3. SEX <b>male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-6-1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 YEAR HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON MD.</b>	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SHEET METAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT MFG</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jerome Rudy</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Poffenberger</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-09-0302A</b>		17. INFORMANT ADDRESS <b>14 N. Cleveland Ave.</b> <b>Ruth Itneyer, Hagerstown, Md.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1991

IMMEDIATE CAUSE (a)

**Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20/1983</b> to <b>7/3/1983</b> , that (I) (we) lost saw the deceased alive on <b>7/3/1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>[Signature]</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABOU WATHEED MD</b>		22e. ADDRESS <b>1600 OAK HILL NE, HAGERSTOWN</b>	

23a. BURIAL, CREMATION, REMOVAL SPECIES <b>burial</b>	23b. DATE <b>July 6, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>
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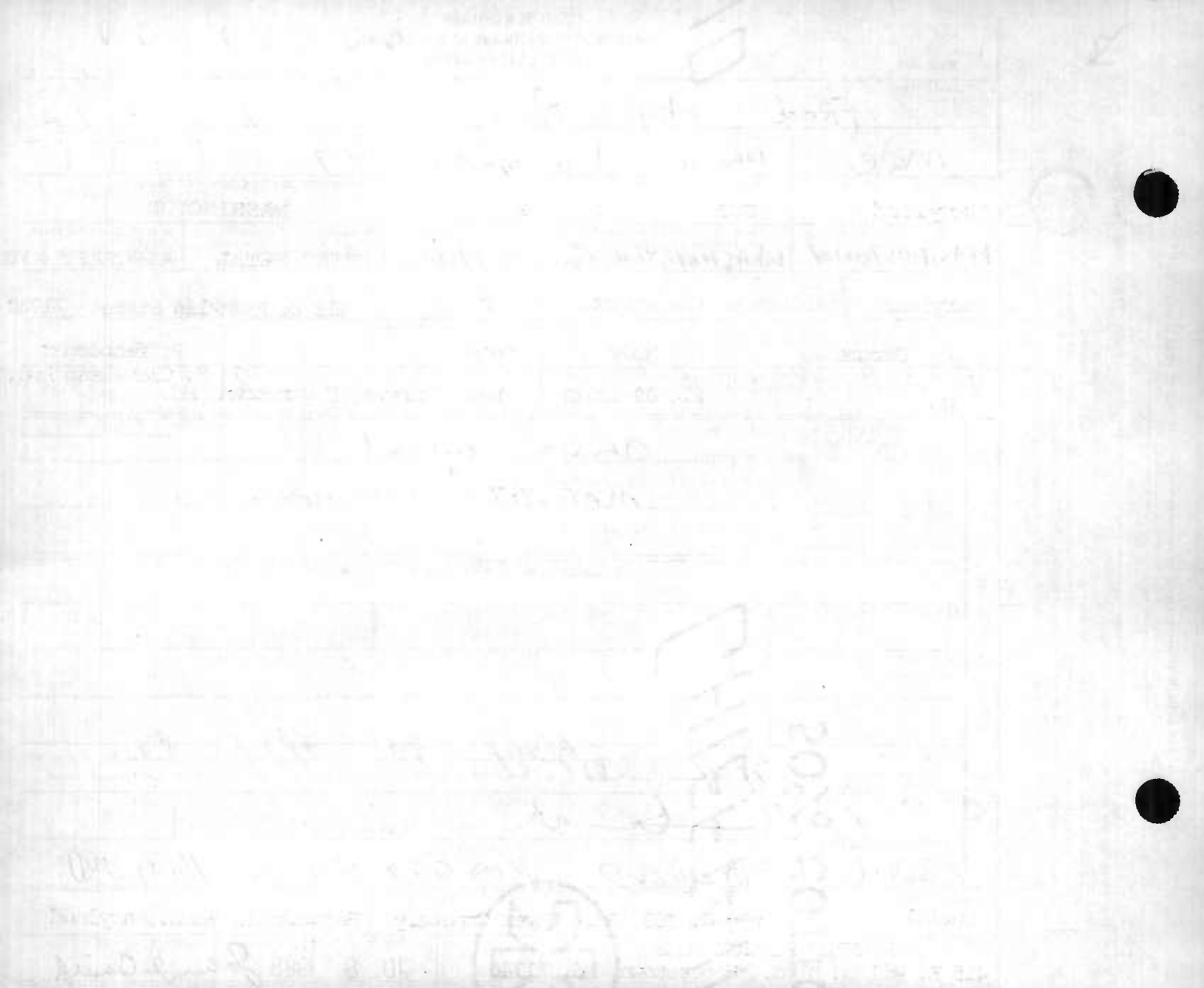
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b> ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>	25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1983</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19910

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Paul (NMN) Salm</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7/2/83</b>		2b. HOUR <b>2:00am</b>
3. SEX <b>MALE</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 5 1966</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>77 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Reeder's Memorial Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Thurmont</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FATHER'S NAME FIRST MIDDLE LAST <b>Sameul Salm</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frieda Grumbaum</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>076-03-3589</b>		17. INFORMANT ADDRESS <b>11109 Putman Road Sandra Singer, Thurmont, Md. 21788</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

**4960**

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Septic Shock**

**Pneumonia**

**End-stage COPD**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**~76 hours**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Chronic Depression**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

IN HOME ☐ NOT WHILE  
AT WORK ☐ AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**R.L. Ryger MD**

**100 Geeting Lane Keedysville, Md.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7/3/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Mem. Gar.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>
24. FUNERAL DIRECTOR NAME <b>G. Douglas Stauffer, Frederick, Md. 21701</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1983</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transfer permit. Their please remove carbon pages. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified immediately.

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James O. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar. Page 3 should be filed in the office of the registrar. Page 4 should be filed in the office of the registrar. Page 5 should be filed in the office of the registrar. Page 6 should be filed in the office of the registrar. Page 7 should be filed in the office of the registrar. Page 8 should be filed in the office of the registrar. Page 9 should be filed in the office of the registrar. Page 10 should be filed in the office of the registrar. Page 11 should be filed in the office of the registrar. Page 12 should be filed in the office of the registrar. Page 13 should be filed in the office of the registrar. Page 14 should be filed in the office of the registrar. 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Page 100 should be filed in the office of the registrar.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH MONTH DAY YEAR		
			Frank Stough SCHWARTZ		July 2, 1983		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
male		white		Dec. 26, 1886		96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		U.S.A.				WASHINGTON MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HAGERSTOWN		AVALON MANOR		Officer		Chemical Corp.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		13f. CITY OR TOWN	
Samuel D. Schwartz		Lizzie Stough		1014 Hamilton Blvd.		21740	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
no		299-07-3155		Mrs. Rachael Schwartz		Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY							
4409 IMMEDIATE CAUSE (a) Congestive Heart Failure							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Atherosclerosis							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
WW Lee		MD					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		July 6, 1983		Rose Hill Cemetery		Hagerstown Wash, Md.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman		Noel Brady		JUL 6 1983		John J. Lister	
		Coffman Funeral Home Inc. Hagerstown, Md.					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 SOM 4/82  
(VRA 15. 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19912

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MADON MAY SEAL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 10 1983</b>			2b. HOUR <b>12:30 AM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 13, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired nurse</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Dickson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Bennett</b>		13e. STREET ADDRESS <b>1620 Marvin Avenue 21740</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>42-30-0862</b>		17. INFORMANT ADDRESS <b>Dorothy S. Dixon, Hagerstown, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Chronic congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension and atherosclerosis of heart</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10-12 years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary emphysema. Mild diabetes mellitus. Presenile dementia.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 30</b> , 19 <b>83</b> , to <b>July 10</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>July 9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <b>examine the body after death.</b>							
22b. SIGNATURE <b>W. T. Layman, M.D.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED <b>July 10, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. T. Layman, M.D.</b>				22e. ADDRESS <b>301 E. ANTIETAM ST. HAGERSTOWN, MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>July 14, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Plainfield, N.J.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Caswell</b>			

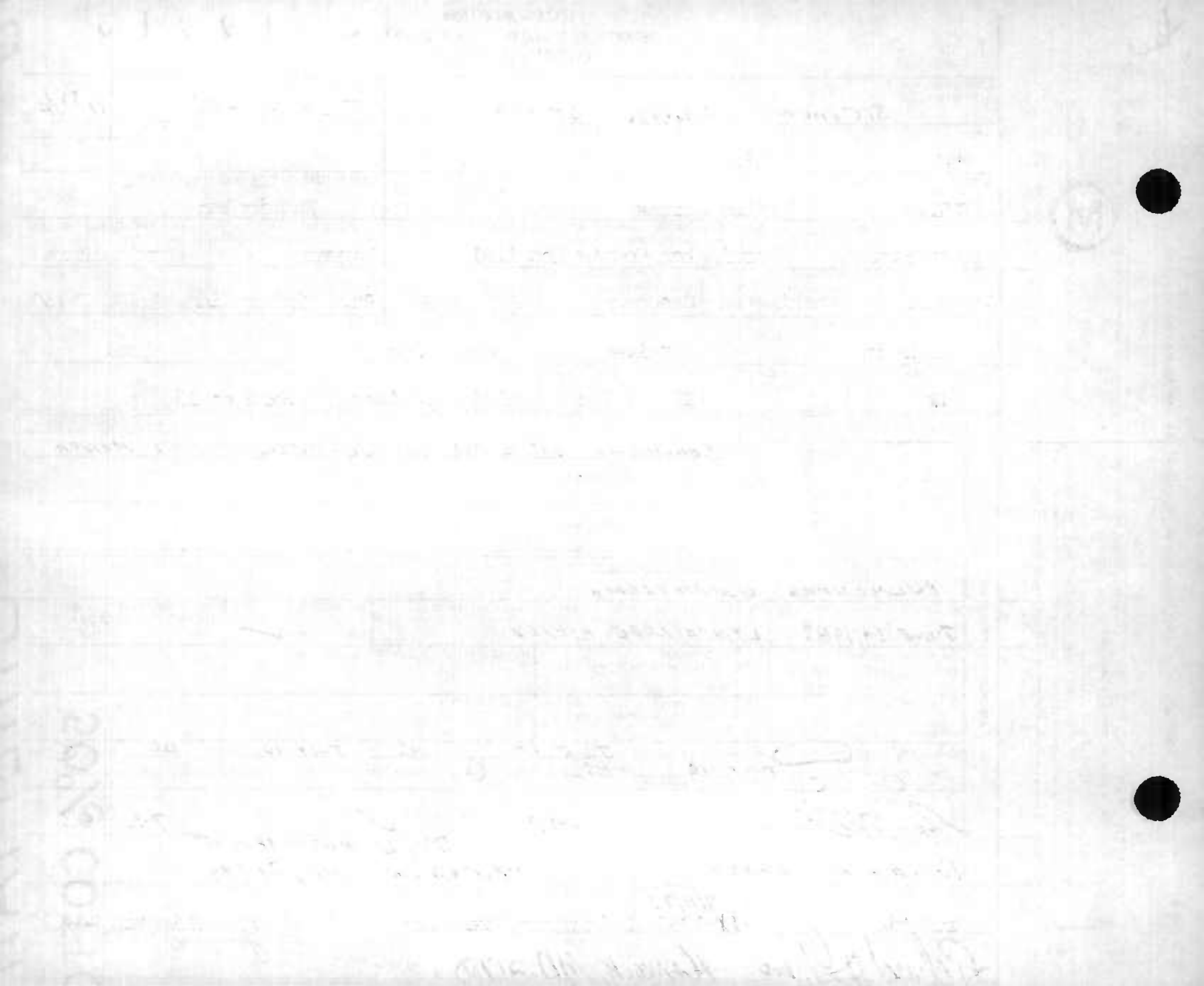




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registry book after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicare certifier must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 19913					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR JULY 10, 1982				2b. HOUR 11:55 A.M.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STEPHEN Shaffer SHIVES				3. SEX Male				4. RACE White	
5. DATE OF BIRTH MONTH DAY YEAR May 13, 1917				6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer				12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				13a. STREET ADDRESS Rt. 2 Timber Ridge # 1 21750	
13a. STATE MARYLAND				13b. COUNTY Washington				13c. CITY OR TOWN Hancock	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Shives				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Reel				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
17. INFORMANT Goldie B. Shives				18. ADDRESS Same as 13				19. SOCIAL SECURITY NO. 212 14 7954	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CARCINOMA OF LUNG, SMALL-CELL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY EMPHYSEMA									
19a. DATE OF OPERATION JUNE 24, 1983				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LYMPH NODE BIOPSY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21c. LOCATION STREET CITY OR TOWN COUNTY STATE				22a. I certify that (I) (this hospital) attended the deceased from JUNE 16, 1983, to JULY 10, 1983, that (I) (we) last saw the deceased alive on JULY 10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature] MD				22c. DATE SIGNED 7-10-83				22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN	
22e. ADDRESS 339 E. ANTIETAM ST HAGERSTOWN, MD, 21740				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					
23b. DATE 7-10-1983				23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington Md 21783	
24. FUNERAL DIRECTOR [Signature] ADDRESS Hancock, MD. 21700				25a. DATE REG'D BY REGISTRAR JUL 20 1983					



BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

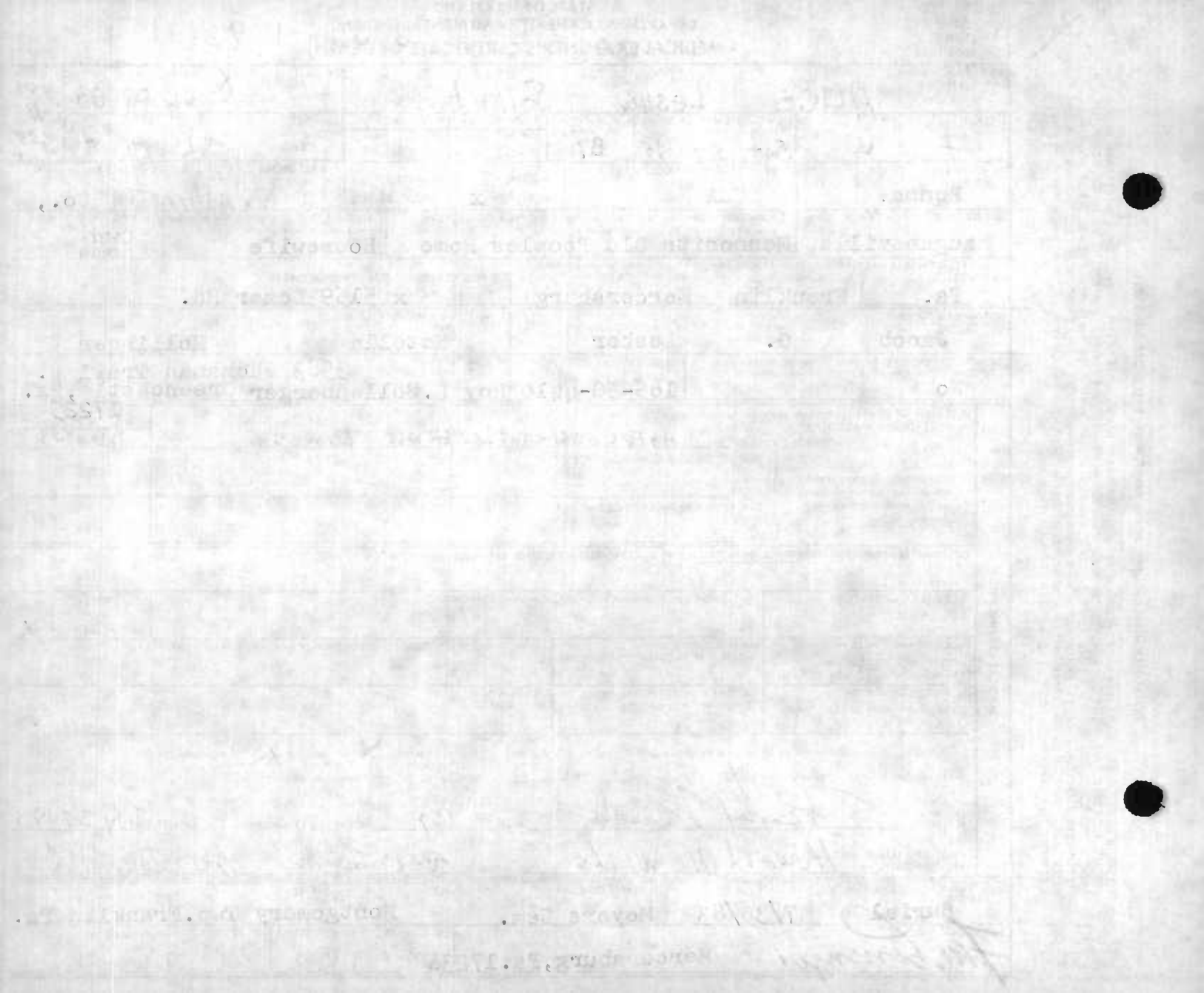
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 19914	
1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> Talbot <sup>MIDDLE</sup> Barden <sup>LAST</sup> Smith						2a. DATE OF DEATH MONTH DAY YEAR July 23, 1983			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto		
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 50 N. Main St.,		21783	
14. FATHER'S NAME <sup>FIRST</sup> Robert <sup>MIDDLE</sup> E. <sup>LAST</sup> Smith				15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Laura <sup>MIDDLE</sup> - <sup>LAST</sup> Busch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. WW I 188-03-0654A		17. INFORMANT ADDRESS Mr. Wilbur R. Sigler, Smithsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>shock fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE PERIOD BETWEEN ONSET AND DEATH <u>5 hours</u> <u>year</u> <u>year</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Obstructive Pulmonary Disease; Cerebral Arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1983</u> , to <u>July 23, 1983</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>July 22, 1983</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>Edmund Henry</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/23/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 25, 1983		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash., Md.					
24. FUNERAL DIRECTOR <u>Dennis L. Davis</u>						25a. DATE REC'D. BY REGISTRAR JUL 27 1983		25b. REGISTRAR'S SIGNATURE <u>Sam J. Carver</u>			
Davis Funeral Home, Smithsburg, Md., 21783											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-9 (ATTACH PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR). PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19915	
FURNAL REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALICE Leshar Sollenberger</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>July 27 1983</b>		2b. HOUR <b>8:05 PM</b>			
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 22 195</b>	6. AGE IN YEARS (LAST BIRTHDAY) <b>87 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <b>July 27 1983</b>		2d. HOUR <b>8:05 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co., MD</b>					
10. CITY OR TOWN OF DEATH <b>Maugansville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mennonite Old Peoples Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Pa.</b>										13b. COUNTY <b>Franklin</b>	
13c. CITY OR TOWN <b>Mercersburg</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>5159 Lemar Rd.</b>										<b>99999</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob G. Leshar</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estella Hollinger</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>165-50-4410</b>		17. INFORMANT <b>Roy L. Sollenberger</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4140 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>						
Canditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					(b) DUE TO, OR AS A CONSEQUENCE OF						
					(c) DUE TO, OR AS A CONSEQUENCE OF						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Howard N. Weeks</b>			TITLE (SPECIFY) <b>Reg</b>			MEDICAL EXAMINER <b>580 North Ave</b>			DATE SIGNED <b>July 27 '83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Howard N. Weeks</b>			ADDRESS <b>Hagerstown, Md</b>								
23a. BURIAL CREMATION REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/30/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meyers Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Montgomery Twp. Franklin Pa.</b>					
24. FUNERAL DIRECTOR <b>Mr. Seminger</b>			ADDRESS <b>Mercersburg, Pa. 17236</b>			25a. DATE REC'D. BY REGISTRAR <b>Aug 01 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Sam E. Connel</b>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

19916

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ROBERT Theodore STARLIPER, Sr.		July 18 1983		3:48 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
male	white	July 13 <sup>th</sup> 1927	56	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		WASH WASHINGTON MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown, Md.	Washington County Hospital	Laborer	Tire & Rubber		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Keedysville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1 Box 182 21756
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
David Luther Starliper		Margret Frances Hebb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		WW 2		Nancy R. Starliper (Item 13 above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1579 IMMEDIATE CAUSE (a) Carcinoma of the pancreas					Apr 1983
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
Apr 11 1983		Obstructive Jaundice		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19		none	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Apr 7, 1983, to July 18, 1983, that (I) (we) last saw the deceased alive on July 15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Francisco G. Japzon, M.D.				July 19 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Francisco G. Japzon, M.D.		645 E. First St. Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	Jul 21, 1983	Mt. View Cemetery		Sharpsburg Washington Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Major M. Osborne		Williamsport, MD 21795		Jul 22 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10	10	10	10	10	10	10	10	10	10
10	10	10	10	10	10	10	10	10	10
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2019 COLLECT

2019 COLLECT

2019 COLLECT

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

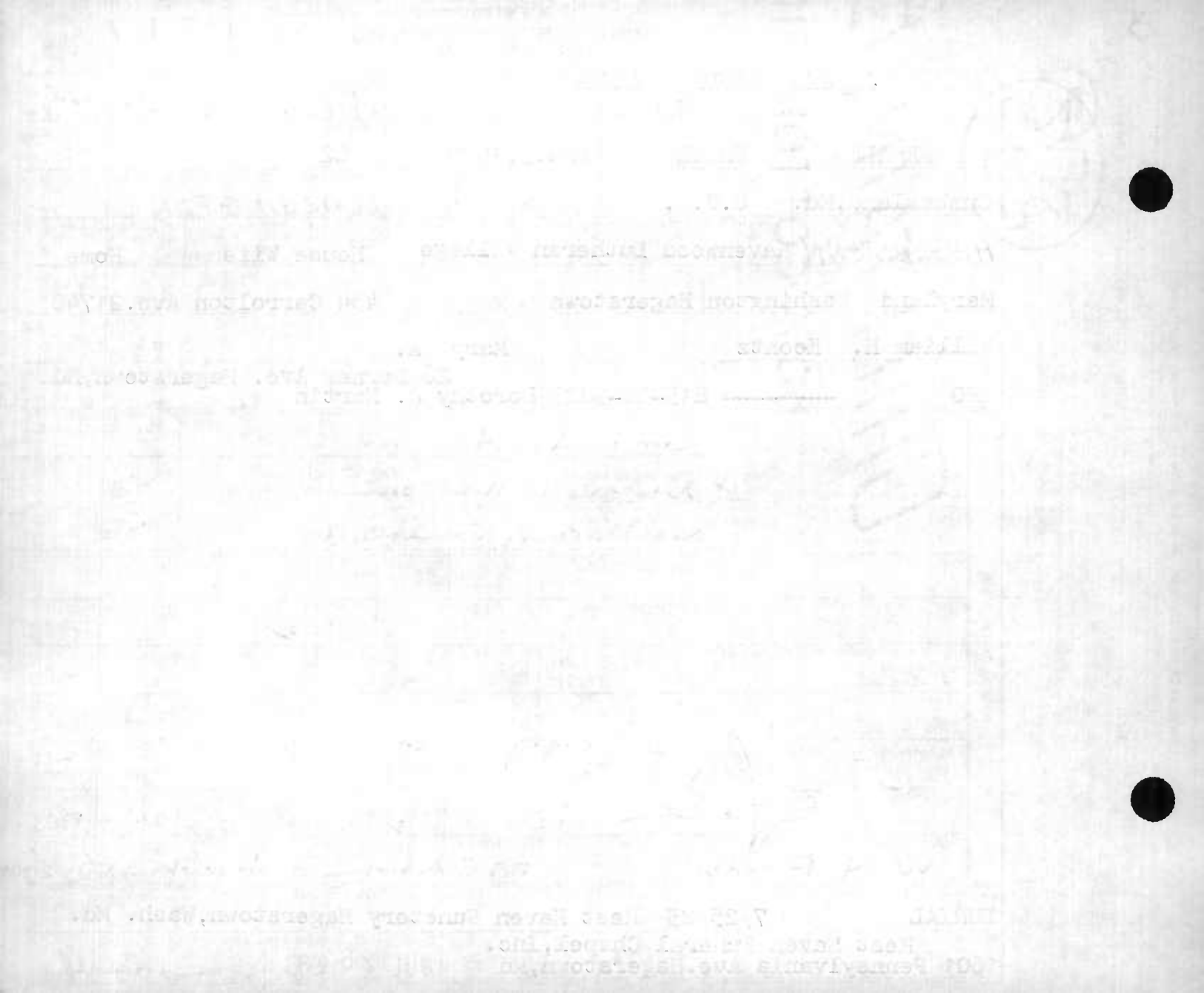
1 DECEASED NAME (TYPE OR PRINT) <b>JESSIE MAUDE STONER</b>		2a DATE OF DEATH MONTH DAY YEAR <b>JULY 21 83</b>		7b HOUR <b>7:45 AM</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>DEC. 9, 1900</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cumberland, Md.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.		
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ravenwood Lutheran Village</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Washington</b> 13c CITY OR TOWN <b>Hagerstown</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Koontz</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary A. " " "</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>215-20-9823</b>		17 INFORMANT <b>Dorothy J. Martin</b>	
26 Berner Ave. Hagerstown, Md. ADDRESS					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anteriorly located Heart Disease</b>		<b>Yes.</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anteriorly located, Generalized</b>		<b>Yes.</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>1 May</u> 19 <u>83</u> to <u>21 July</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>21 July</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <b>W. N. Fender</b> MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>22 July 1983</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. N. Fender</b>		22e ADDRESS <b>138 E. Antietam St., Hagerstown, Md. 21740</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b DATE <b>7/25/83</b>	23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash. Md.</b>
24 FUNERAL DIRECTOR NAME <b>Rest Haven Funeral Chapel, Inc.</b> ADDRESS <b>1601 Pennsylvania Ave. Hagerstown, Md</b>		25a DATE REC'D. BY REGISTRAR <b>JUL 26 1983</b>	25b REGISTRAR'S SIGNATURE <b>John J. Canine</b>



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19918

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN VIRGINIA STOVER</b> <i>HELEN STOVER</i>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 28 83</b>		2b. HOUR MIN. <b>9:15 P M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 5, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Wash.</b>	13c. CITY OR TOWN <b>Funkstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>21734 12 E. Green St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Edward Socks</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Estelle "Henretta"</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-14-6104</b>		17. INFORMANT ADDRESS <b>Mary J. Kenyon/ same as 13 e</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5768 IMMEDIATE CAUSE (a) <u>Septicemia</u></b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>extra abdominal abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disruption cholecystectomy 4 wks</u> 3 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus</b>					
19a. DATE OF OPERATION <b>6/1/83</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obstructive jaundice with abdominal distention</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/1 1983</b> to <b>7/28 1983</b> , that (I) <del>lost</del> saw the deceased alive on <b>7/28 1983</b> , and that in (my) <del>low</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <del>did</del> <del>did not</del> view the body after death.					
22b. SIGNATURE <b>John R. Marsh, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/28/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN R. MARSH, M.D.</b>		22e. ADDRESS <b>239 N. Potomac St. HAGERSTOWN, MD. 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>8/1/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave. Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 03 1983</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9 4 2 9



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, no cause of injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				19919			
1. DECEASED NAME (TYPE OR PRINT) <b>Julia Ellen Summers</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 19, 1983</b>		2b. HOUR <b>7:45 p.m.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>January 28, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garlock Memorial Convalescent Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Henry Groff</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estella Virginia Jacobs</b>		13e. STREET ADDRESS <b>1032 Concord Street</b> 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-74-2148</b>		17. INFORMANT <b>Evelyn V. King Williamsport, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Obstr. pulm. disease</b>							
19a. DATE OF OPERATION <b>May 83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholelithiasis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-30</b> , 19 <b>81</b> , to <b>7-19</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>5-27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. Hoachlander</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7-20-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eldon G. Hoachlander MD</b>				22e. ADDRESS <b>Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-22-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Pk. Hagerstown, Washington, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>				25a. DATE REC'D BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <b>JUL 25 1983 John L. Lauer</b>			

BP \_\_\_\_\_



7:45 p

July 19, 1983

Waters

Miller

Julia

86

January 28, 1977

White

Female

Washington County

X

U.S.A.

Maryland

Garlock Memorial Convalescent Home, Harpersville

Harpersville

2140

1032 Concord Street

X

Washington, Harpersville

Maryland

Jacobs

Virginia

Bastin

Groff

Henry

William

7 East Reynolds Road

Reynolds V. King, Williamsport, Md.

213-7A-21A8

- - -

No

83

7-19

81

4-30 83

2-27

7-20-83

Harpersville, Maryland

Edison G. Harpersville MD

John Law Memorial H. Harpersville, Washington, Md.

7-20-83

Initial

A.A. Bellman Memorial Home, Inc., Harpersville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Goldie Mae Taylor</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 19 1983</b>			2b. HOUR <b>3:10 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 3, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Garment</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RFD-2 Box 133</b>		13f. STREET ADDRESS <b>21740</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William C. Shoemaker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Snyder</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-14-6658</b>		17. INFORMANT ADDRESS <b>Mr. Fred Taylor RFD-2 Hag.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5150

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Dwight Wooster</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/19/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dwight Wooster MD</b>				22e. ADDRESS <b>1825 Howell Road Hager. Md</b>			

23a. BURIAL, CREMATION, REMOVAL SPECIES <b>Burial</b>		23b. DATE <b>July 22, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clearspring Wash. Md.</b>	
24. FUNERAL DIRECTOR <b>Thompson Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1983</b>			
25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>							

100% COTTON

Washing

Washington County

Washington County

G. Thompson

Washington County

Washington

Washington

Washington

Washington

Washington

Washington

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #5&6 Film G581 7/12/83 rc				STATE OF MARYLAND				1 9 9 2 1			
1- FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Dolores Taylor				7-4-83				750 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		white		August 11, 1912		70-71 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Washington MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital						housewife			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland				Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS			
FIRST MIDDLE LAST				FIRST MIDDLE LAST				21740			
Thumma				Eva				1743 Edgewood Hill Cir.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No						Rev. Frank Taylor, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE			
22a. certify that (i) (this hospital) attended the deceased from 9/16, 1980, to 7/2, 1983, that (i) (we) lost the deceased on 7-4-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
E R Lord								7-4-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
E R Lord				382 South Cleveland, Hagerstown, Md							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
burial				July 7, 1983		Greenlawn Mem. Park		Williamsport, Wash., Md.			
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR			
MINNICH FUNERAL HOME								JUL 8 1983			
415 E. Wilson Blvd., Hagerstown, Md. 21740								John J. Smith			



1942	1941	1940	1939	1938	1937	1936	1935	1934	1933	1932	1931	1930	1929	1928	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917	1916	1915	1914	1913	1912	1911	1910	1909	1908	1907	1906	1905	1904	1903	1902	1901	1900	1899	1898	1897	1896	1895	1894	1893	1892	1891	1890	1889	1888	1887	1886	1885	1884	1883	1882	1881	1880	1879	1878	1877	1876	1875	1874	1873	1872	1871	1870	1869	1868	1867	1866	1865	1864	1863	1862	1861	1860	1859	1858	1857	1856	1855	1854	1853	1852	1851	1850	1849	1848	1847	1846	1845	1844	1843	1842	1841	1840	1839	1838	1837	1836	1835	1834	1833	1832	1831	1830	1829	1828	1827	1826	1825	1824	1823	1822	1821	1820	1819	1818	1817	1816	1815	1814	1813	1812	1811	1810	1809	1808	1807	1806	1805	1804	1803	1802	1801	1800	1799	1798	1797	1796	1795	1794	1793	1792	1791	1790	1789	1788	1787	1786	1785	1784	1783	1782	1781	1780	1779	1778	1777	1776	1775	1774	1773	1772	1771	1770	1769	1768	1767	1766	1765	1764	1763	1762	1761	1760	1759	1758	1757	1756	1755	1754	1753	1752	1751	1750	1749	1748	1747	1746	1745	1744	1743	1742	1741	1740	1739	1738	1737	1736	1735	1734	1733	1732	1731	1730	1729	1728	1727	1726	1725	1724	1723	1722	1721	1720	1719	1718	1717	1716	1715	1714	1713	1712	1711	1710	1709	1708	1707	1706	1705	1704	1703	1702	1701	1700	1699	1698	1697	1696	1695	1694	1693	1692	1691	1690	1689	1688	1687	1686	1685	1684	1683	1682	1681	1680	1679	1678	1677	1676	1675	1674	1673	1672	1671	1670	1669	1668	1667	1666	1665	1664	1663	1662	1661	1660	1659	1658	1657	1656	1655	1654	1653	1652	1651	1650	1649	1648	1647	1646	1645	1644	1643	1642	1641	1640	1639	1638	1637	1636	1635	1634	1633	1632	1631	1630	1629	1628	1627	1626	1625	1624	1623	1622	1621	1620	1619	1618	1617	1616	1615	1614	1613	1612	1611	1610	1609	1608	1607	1606	1605	1604	1603	1602	1601	1600	1599	1598	1597	1596	1595	1594	1593	1592	1591	1590	1589	1588	1587	1586	1585	1584	1583	1582	1581	1580	1579	1578	1577	1576	1575	1574	1573	1572	1571	1570	1569	1568	1567	1566	1565	1564	1563	1562	1561	1560	1559	1558	1557	1556	1555	1554	1553	1552	1551	1550	1549	1548	1547	1546	1545	1544	1543	1542	1541	1540	1539	1538	1537	1536	1535	1534	1533	1532	1531	1530	1529	1528	1527	1526	1525	1524	1523	1522	1521	1520	1519	1518	1517	1516	1515	1514	1513	1512	1511	1510	1509	1508	1507	1506	1505	1504	1503	1502	1501	1500	1499	1498	1497	1496	1495	1494	1493	1492	1491	1490	1489	1488	1487	1486	1485	1484	1483	1482	1481	1480	1479	1478	1477	1476	1475	1474	1473	1472	1471	1470	1469	1468	1467	1466	1465	1464	1463	1462	1461	1460	1459	1458	1457	1456	1455	1454	1453	1452	1451	1450	1449	1448	1447	1446	1445	1444	1443	1442	1441	1440	1439	1438	1437	1436	1435	1434	1433	1432	1431	1430	1429	1428	1427	1426	1425	1424	1423	1422	1421	1420	1419	1418	1417	1416	1415	1414	1413	1412	1411	1410	1409	1408	1407	1406	1405	1404	1403	1402	1401	1400	1399	1398	1397	1396	1395	1394	1393	1392	1391	1390	1389	1388	1387	1386	1385	1384	1383	1382	1381	1380	1379	1378	1377	1376	1375	1374	1373	1372	1371	1370	1369	1368	1367	1366	1365	1364	1363	1362	1361	1360	1359	1358	1357	1356	1355	1354	1353	1352	1351	1350	1349	1348	1347	1346	1345	1344	1343	1342	1341	1340	1339	1338	1337	1336	1335	1334	1333	1332	1331	1330	1329	1328	1327	1326	1325	1324	1323	1322	1321	1320	1319	1318	1317	1316	1315	1314	1313	1312	1311	1310	1309	1308	1307	1306	1305	1304	1303	1302	1301	1300	1299	1298	1297	1296	1295	1294	1293	1292	1291	1290	1289	1288	1287	1286	1285	1284	1283	1282	1281	1280	1279	1278	1277	1276	1275	1274	1273	1272	1271	1270	1269	1268	1267	1266	1265	1264	1263	1262	1261	1260	1259	1258	1257	1256	1255	1254	1253	1252	1251	1250	1249	1248	1247	1246	1245	1244	1243	1242	1241	1240	1239	1238	1237	1236	1235	1234	1233	1232	1231	1230	1229	1228	1227	1226	1225	1224	1223	1222	1221	1220	1219	1218	1217	1216	1215	1214	1213	1212	1211	1210	1209	1208	1207	1206	1205	1204	1203	1202	1201	1200	1199	1198	1197	1196	1195	1194	1193	1192	1191	1190	1189	1188	1187	1186	1185	1184	1183	1182	1181	1180	1179	1178	1177	1176	1175	1174	1173	1172	1171	1170	1169	1168	1167	1166	1165	1164	1163	1162	1161	1160	1159	1158	1157	1156	1155	1154	1153	1152	1151	1150	1149	1148	1147	1146	1145	1144	1143	1142	1141	1140	1139	1138	1137	1136	1135	1134	1133	1132	1131	1130	1129	1128	1127	1126	1125	1124	1123	1122	1121	1120	1119	1118	1117	1116	1115	1114	1113	1112	1111	1110	1109	1108	1107	1106	1105	1104	1103	1102	1101	1100	1099	1098	1097	1096	1095	1094	1093	1092	1091	1090	1089	1088	1087	1086	1085	1084	1083	1082	1081	1080	1079	1078	1077	1076	1075	1074	1073	1072	1071	1070	1069	1068	1067	1066	1065	1064	1063	1062	1061	1060	1059	1058	1057	1056	1055	1054	1053	1052	1051	1050	1049	1048	1047	1046	1045	1044	1043	1042	1041	1040	1039	1038	1037	1036	1035	1034	1033	1032	1031	1030	1029	1028	1027	1026	1025	1024	1023	1022	1021	1020	1019	1018	1017	1016	1015	1014	1013	1012	1011	1010	1009	1008	1007	1006	1005	1004	1003	1002	1001	1000	999	998	997	996	995	994	993	992	991	990	989	988	987	986	985	984	983	982	981	980	979	978	977	976	975	974	973	972	971	970	969	968	967	966	965	964	963	962	961	960	959	958	957	956	955	954	953	952	951	950	949	948	947	946	945	944	943	942	941	940	939	938	937	936	935	934	933	932	931	930	929	928	927	926	925	924	923	922	921	920	919	918	917	916	915	914	913	912	911	910	909	908	907	906	905	904	903	902	901	900	899	898	897	896	895	894	893	892	891	890	889	888	887	886	885	884	883	882	881	880	879	878	877	876	875	874	873	872	871	870	869	868	867	866	865	864	863	862	861	860	859	858	857	856	855	854	853	852	851	850	849	848	847	846	845	844	843	842	841	840	839	838	837	836	835	834	833	832	831	830	829	828	827	826	825	824	823	822	821	820	819	818	817	816	815	814	813	812	811	810	809	808	807	806	805	804	803	802	801	800	799	798	797	796	795	794	793	792	791	790	789	788	787	786	785	784	783	782	781	780	779	778	777	776	775	774	773	772	771	770	769	768	767	766	765	764	763	762	761	760	759	758	757	756	755	754	753	752	751	750	749	748	747	746	745	744	743	742	741	740	739	738	737	736	735	734	733	732	731	730	729	728	727	726	725	724	723	722	721	720	719	718	717	716	715	714	713	712	711	710	709	708	707	706	705	704	703	702	701	700	699	698	697	696	695	694	693	692	691	690	689	688	687	686	685	684	683	682	681	680	679	678	677	676	675	674	673	672	671	670	669	668	667	666	665	664	663	662	661	660	659	658	657	656	655	654	653	652	651	650	649	648	647	646	645	644	643	642	641	640	639	638	637	636	635	634	633	632	631	630	629	628	627	626	625	624	623	622	621	620	619	618	617	616	615	614	613	612	611	610	609	608	607	606	605	604	603	602	601	600	599	598	597	596	595	594	593	592	591	590	589	588	587	586	585	584	583	582	581	580	579	578	577	576	575	574	573	572	571	570	569	568	567	566	565	564	563	562	561	560	559	558	557	556	555	554	553	552	551	550	549	548	547	546	545	544	543	542	541	540	539	538	537	536	535	534	533	532	531	530	529	528	527	526	525	524	523	52
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				19922			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Alice May Thomas				7 10 83				6:15 P.M.			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		March 25, 1882		101		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				WASHINGTON MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Boonsboro		Reeders Memorial Home				Domestic		Home			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Maryland				Washington		Williamsport		N. Conococheague St. 21795			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Unknown				Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
no				220-30-9216		Laura Redmond/3500 Mayfair Rd. Balt. MD 21207					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) 5860								3 months			
DUE TO, OR AS A CONSEQUENCE OF (b) and											
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Myalgia Rheumatica											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED			
				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2			
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1983 to 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
P. L. Kugler MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
P. L. Kugler				100 Geeting Lane				Keedysville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				July 13, 1983		Riverview Cemetery		Williamsport Washington Maryland			
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Major M. Osborne				JUL 15 1983				John J. Carver			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19923

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARIE Lillian TRACEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-12-83</b>		2b. HOUR <b>8:38</b> M	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 20, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>						

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Wash.</b>	13c. CITY OR TOWN <b>Smithsburg</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Rt. 1, Box 459</b> <b>21783</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy Sheffler</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-10-3027</b>		17. INFORMANT ADDRESS <b>Mr. Merle C. Tracey, Smithsburg, Md.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2500 IMMEDIATE CAUSE (a) CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <b>Hypertension Arteriosclerotic Heart Disease 20 yrs</b>	
(c) <b>Diphtheria Mellitus</b>		<b>2 yrs</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22. I certify that (I) (this hospital) attended the deceased from **19/83** to **7/12/83**, that (I) (we) last saw the deceased alive on **7/12/83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE <b>D. E. Martin</b>	DEGREE <b>MD</b>	22b. DATE SIGNED <b>7/13/83</b>
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD E. MARTIN</b>		22d. ADDRESS <b>3635 Cleveland Ave Hagerstown</b>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 16, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Md.</b>
24. FUNERAL DIRECTOR NAME <b>Dennis J. Davis</b> <b>Davis Funeral Home, Smithsburg, Md., 21783</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1983</b> REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes and stamps on a document, including a large 'M' in a circle on the right side and various illegible markings.

FOR  
1- STATE REGISTRAR **William Robert Warburton** CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Robert WARBURTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-1-83</b>		2b. HOUR <b>5:30</b> AM
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-9-1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Press Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Warburton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte Cramer Campbell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>298-07-1072</b>		17. INFORMANT <b>Betty Jane Smith</b> ADDRESS <b>117 W. Howard Street Hagerstown, Md. 21740</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **cardiac arrest****5770**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **acute pancreatitis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/30/83</b> to <b>7/1/83</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WAHED MD</b>				22e. ADDRESS <b>600 Oak Hill NE Hgt. MD 21740</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>7-4-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematorium</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Washington Md.</b>
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 5 1983</b>	

24. FUNERAL DIRECTOR

NAME  
**A.K. Coffman Funeral Home, Inc., Hagerstown, Md.**

ADDRESS

25a. DATE REC'D. BY REGISTRAR

**JUL 5 1983**

25. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

No

- - -

Robert

Washington

Charlotte

Charlotte

228-01-1072 Betty Jane Smith

117 W. Howard Street  
Harrisburg, Pa. 17102

212 Fairview Avenue

Maryland Washington Harrisburg

Press Operator Printing Co.  
21210

Ohio

U.S.A.

Washington County

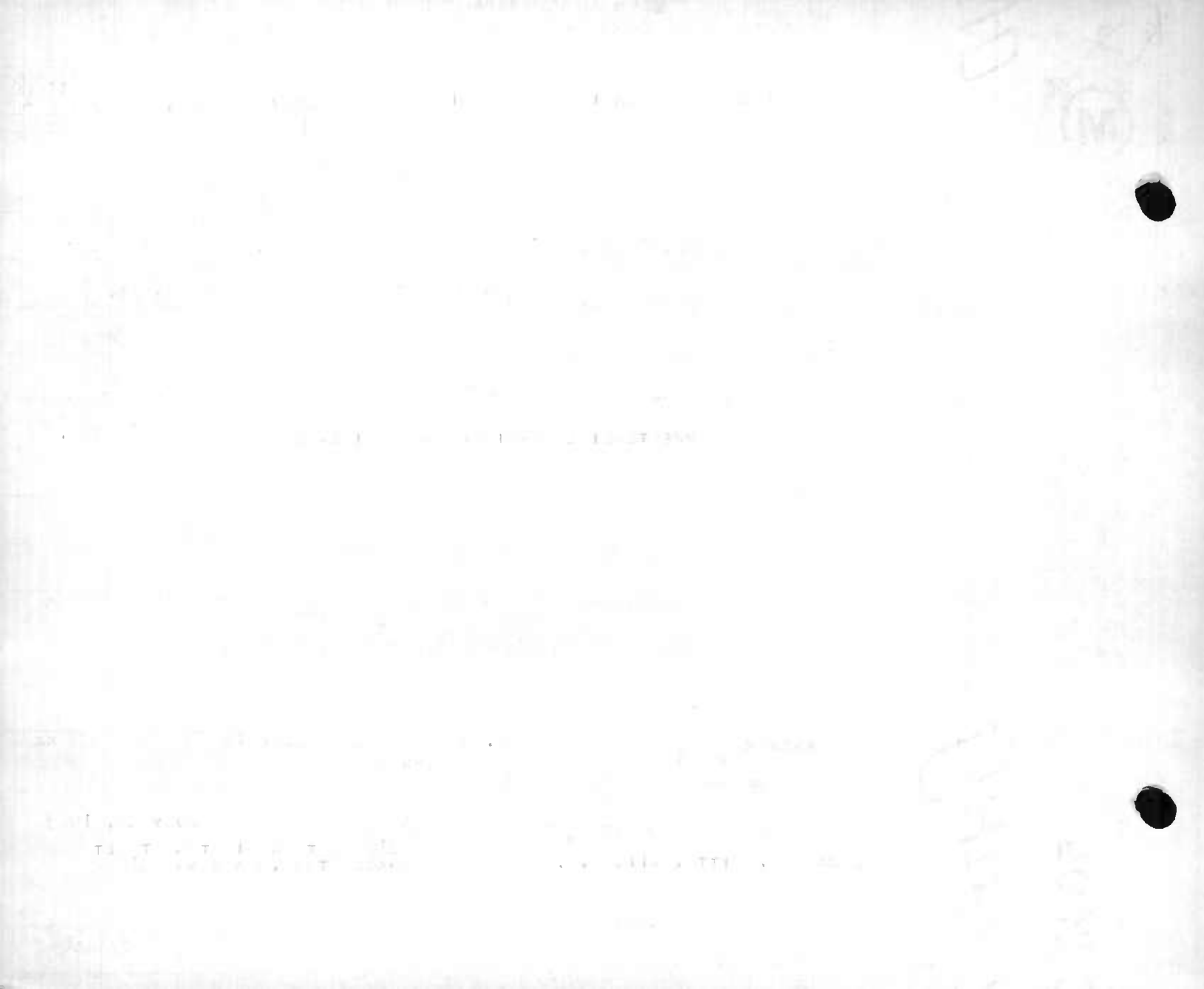
William Robert Harrison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>GEORGE DAVID WHIPP</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>26</b> , Year <b>1983</b>			2b. HOUR <b>11:00</b> A M			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Oct. 6, 1930</b>		6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>52 E. Antietam St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>self employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>painter</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>21740</b> <b>52 E. Antietam St.</b>	
14. FATHER'S NAME First <b>George</b> Middle <b>H.</b> Last <b>Whipp</b>			15. MOTHER'S MAIDEN NAME First <b>Ersa</b> Middle <b>Coneice</b> Last <b>Coneice</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>1947-1949</b>		17. INFORMANT <b>Betty J. Davis</b>		Address <b>1810 Heisterboro Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(the physician)</del> attended the deceased from <b>Nov. 3</b> , 19 <b>82</b> , to <b>JUNE 13</b> , 19 <b>83</b> , that (I) <del>(we)</del> lost the deceased alive on <b>JUNE 13</b> , 19 <b>83</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.									
22b. SIGNATURE <i>Edward W. Ditto III</i>				22c. DATE SIGNED <b>JULY 27, 1983</b>		22d. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTO, III, M.D.</b>			
22e. ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE <b>July 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithburg Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Smithburg Washington Md.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b> <b>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>				25a. REC'D BY REGISTRAR <b>AUG 01 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19926	
FOR item 22a film 582 STATE REGISTRAR 8-2-83 cn										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARIA Louisa WILLIAMS</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>JUL 6 1983</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 31 56</b>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>27 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>JUL 6 1983</b>		2b. HOUR <b>4 am</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemical Eng. Dupont Corp.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Delaware</b>		13b. COUNTY <b>Wilmington</b>		13c. CITY OR TOWN <b>Wilmington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>302 SHIPLEY RD</b>		<b>99995</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earle Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ventura Armstrong</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>131-44-5624</b>		17. INFORMANT ADDRESS <b>Mrs Ventura Williams 217-39 114th Rd, Cambria Hgts, N.Y.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>427</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Massive head trauma</b> <b>N869 E 812</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:30 P.M. JUL 5 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Automobile accident</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>I-70 &amp; 522</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Hancock MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Allen W Ditt</b>				TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>7/6/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Allen W Ditt MD</b>				ADDRESS <b>1610 Oak Hill Ave Hagerstown</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jul 9 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pinelawn Mem Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suffolk Co, New York</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>NUTTER &amp; SONS 2501 GWYNNS FALLS PKWY</b>						25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>JUL 8 1983 John J. Carter</b>					



NEW YORK

100-100000

100-100000

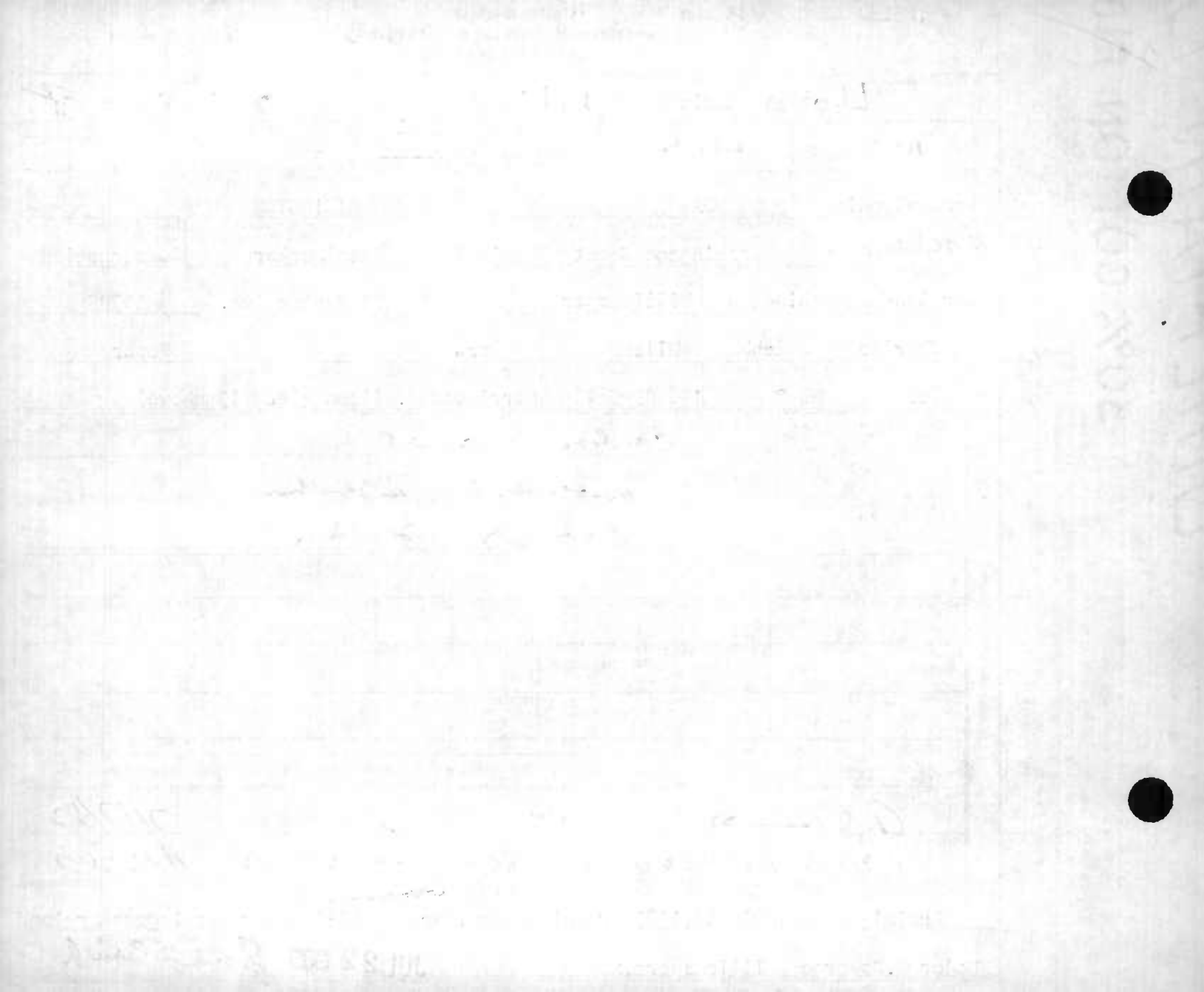
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#5, Film G582 8/29/83 kam										STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		19927					
1- STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>LLOYD Merle WILSON</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>7-17-83</b>				2b. HOUR <b>2:58</b> AM					
3. SEX <b>M</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>January 26, 1911</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.										
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steelworker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21 Fenton Ave. 21795</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Zebb Wilson</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora Poper</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>										16b. SOCIAL SECURITY NO <b>WW 2</b>		17. INFORMANT ADDRESS <b>Harriette A. Wilson (item 13 above)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarction</b>																			
(c) <b>expired peacefully</b>																			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/17/83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WATHEAD MD</b>										22e. ADDRESS <b>1600 Oak Hill Ave. Hagerstown</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 20, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport Washington Maryland</b>									
24. FUNERAL DIRECTOR NAME <b>Major M. Osborne Williamsport, MD</b> ADDRESS										25a. DATE REC'D. BY REGISTRAR <b>JUL 22 1983</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>									

BP

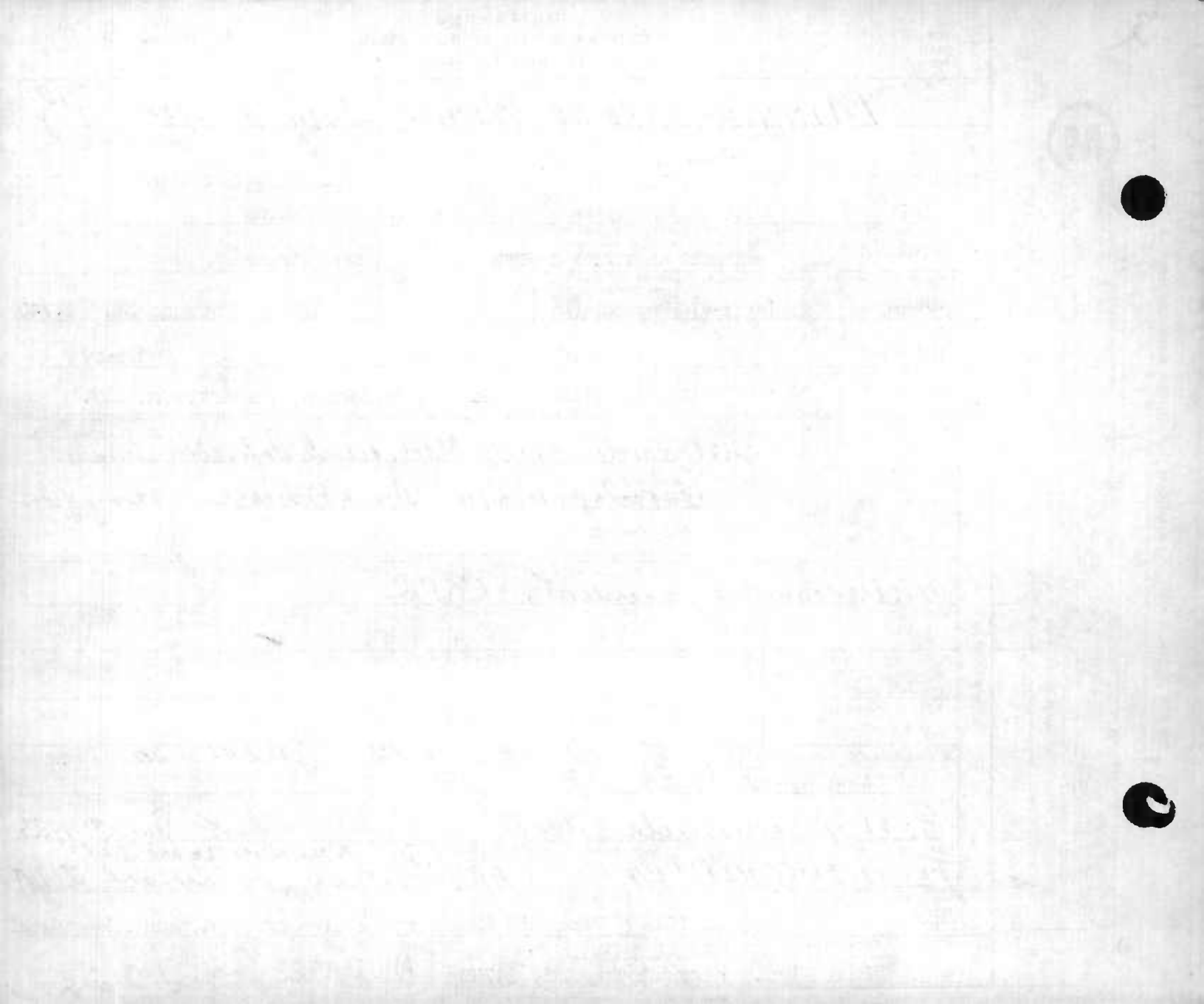


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Post-mortem examination must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		19928							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>MINNIE FLORENCE WITHER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 31 1983</b>		2b. HOUR <b>1:12</b> PM	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 29, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTERN MARYLAND CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13e. STREET ADDRESS <b>136 N. Potomac St. 21740</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Orebaugh</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Leacy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-26-0108</b>		17. INFORMANT ADDRESS <b>Ada Mae Anderson, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>4100 POSSIBLE Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronopetrotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>many years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>Cerebrovascular accident, C.P.D.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov 26</b> , 19 <b>82</b> , to <b>July 31</b> , 19 <b>83</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>July 31</b> , 19 <b>83</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.									
22b. SIGNATURE <b>Fe U. Porciuncula M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>July 31, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FE U. PORCIUNCULA</b>						22e. ADDRESS <b>1500 PENNSYLVANIA AVE. HAGERSTOWN, MARYLAND 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 2, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1983</b>			
415 E. Wilson Blvd., Hagerstown, Md. 21740						25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

19929

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA WYATT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 31, 1983</b>			2b. HOUR <b>3:00 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 21, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Maugansville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maugansville Mennonite Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Big Pool</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RFD-1 21711</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel O. Wyatt</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jenny Buchanan</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>229-72-2732</b>		17. INFORMANT <b>Mrs. Wm. Wyatt</b>				ADDRESS <b>Big Pool Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Failure</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death <b>Natural Cause</b>										
22b. SIGNATURE <b>Donald E. Thompson</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 2, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shanktown</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Big Pool Wash. Md.</b>			
24. FUNERAL DIRECTOR (NAME) <b>Donald E. Thompson</b> <b>Thompson Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cahill</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHIEF



W. S. 33 Shannon

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